THE INVINCIBLE DEFEAT OF A VIOLENT INNOCENT

Entertaining paradox and paranoia in the therapy of a borderline patient

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DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: Mary-Ann Collins Date: 30th June 2009

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ABSTRACT

In this thesis I use the case study to understand and interpret the manifested transference-countertransference anxiety in the therapy as it was expressed largely through the patient's and the therapist's paranoia. The experience of the sense of aliveness and deadness in the therapeutic hour, and the function that this interactive space have played in pointing me to my patient's internal object world and her object relations are explored in terms of their usefulness in understanding the therapeutic impasse.

I suggest that my patient's 'substitute formations' in the place of good object relating, reflected in the perverse pleasure she obtained from what has been termed 'violent innocence', for some time masked the lifelessness of the analysis. I link the denial of others' perceptions that violent innocence entails to intersubjective theories of mutual recognition, and trace the failure to successfully negotiate the 'crisis of recognition' in early childhood to the maintenance of a magical omnipotence in adult relating. I explore how the domination of intrapsychic contents negatively affects the successful development in the individual of empathy, concern and connectedness.

I examine the way in which supportive therapeutic techniques in the therapy of patients with borderline attachment difficulties may well provide temporary adjustments, but run the risk of failing to provide for a higher level of psychic integration beyond support for the development of a false self. I look at the way in which the false self may emerge as a distortion of the 'dense logics of deception' that are paradoxically involved in the negotiation of a shared reality with others.

I conclude by suggesting that the stalemating of the therapy, because it involves both the defeat of the therapist and the patient in apparently invincible ways, is a useful, if not necessary, stage within the regression and the recovery of both the borderline patient's transference and the therapist's countertransference. I argue that reflecting the transference-countertransference material through the use of concurrent and equivalent modes of self relating in order to model the patient's false self representations, may offer the best way forward in the treatment of borderline patients for whom object relations are constituted through summoning turbulence.

CHAPTER ONE

INTRODUCTION

The genesis for this thesis lay in a compelling sense of how the frustration that I had experienced in the therapy of a patient, was informed not only by the emergence of her paranoid object relating, and by the concomitant presence of my own situational paranoia as an intern psychologist, but by the interaction of these two subjectivities. Only by reviewing the therapy in the light of intersubjectivity theory, particularly those of the relational theorists, was I able to understand that the therapeutic techniques I used to assist my patient to put some distance between her and her disorganised outbursts, had in fact re-enacted the peculiar form of 'deadness' she had experienced with her early care-giver. Paradoxically, when she accessed quiescence she experienced it as emptiness, and anger, omnipotence, envy and grandiosity were the affect-laden states that she preferred in order to retain her sense of aliveness.

The focus question

The theoretical focus of this thesis seeks to examine the sponsoring of false selves within the therapeutic space of both the patient and the therapist, and to identify the transference and countertransference anxiety in the therapy. Intersubjective interactions arising in the therapy are used to explore my patient's vigorous attempt to reconstitute the emotional turmoil of a deeply disturbed early relationship in the face of my attempts to get her to put boundaries in place and to adapt to her surroundings. I look at the paradoxical role that *mis*recognition plays in the complex process of mutual recognition, and at the grandiose false self's disavowal of others' perceptions – a disavowal process that often entails a refusal to misrecognise in the interests of better communication. Through analysing the intersubjective dysjunction that occurred in the therapy, I track how I eventually came to look at my patient's perverse substitutes for mutual recognition as constituting unconscious gratifications, rather than malignant resistances - gratifications that may well have served the purpose of bringing 'aliveness' (or the organising power of the early object of borderline desire) into the therapy - and I touch on the challenges that this presented for me as the therapist.

In Chapter Two I draw on relational theories of development to explain how unsuccessful negotiation of the destruction-recognition crisis at the rapprochement phase of separation-

individuation can disable the creation of a transitional space. I link the failure to balance intrapsychic and intersubjective elements in the space between the mother and infant to the failure to negotiate this transitional space in the therapeutic relationship. In particular I look at the notion of omnipotence with regard to the infant's needed experience of being able to destroy its object safely, and at how mutual recognition is furthered through the paradoxical process of gradual disillusionment that the nurturing caregiver provides for the infant.

Methodologically I have elected to work within the qualitative paradigm, focussing on the single case study. In Chapter Three I look at how epistemologically the case study lends itself to a qualitative method of exploration, highlighting as it does the particular and the idiosyncratic, and lending itself to psychoanalytically-minded individuals' receptiveness for narrative forms that integrate feelings and thoughts.

Additionally, because the case study provides for vicarious learning through the researcher-therapist's symbolisation of visceral and previously unintegrated feelings and thoughts, there is a distinct metabolising function that the case study provides. This function is applicable to the often indigestible material that emerged in the therapy, and itself mirrors the optimal early caregiving that is seen to engender healthy development and the capacity for symbolisation in the individual. Firstly, the qualitative case-study process requires one as a therapist to have a readiness for an intensely visceral kind of sensing. Secondly, the process requires of the therapist a capacity to be a container or the recipient of unpleasant, 'bad' feelings that the patient wishes to rid him/herself of. Thirdly, the process requires the therapist (who is now also a researcher) to metabolise the projections of the patient in such a way as to render them digestible to both the patient and the reader. The way in which the researcher symbolises visceral material provides the means by which the reader can internalise material that the reader cannot afford to take on at first hand.

In Chapter Four I present a brief case history that sets out much of the background that this case study requires in order to establish the context in which the patient's primary conflicts arise. In Chapter Five I propose a formulation that presents a diagnosis of narcissistic and borderline personality disorder establishing the deficits in the structure of the self that are the characteristic features of this disorder, and link these primarily to parental failures of attunement. This is useful for an initial linking of the patient's characterological deficits to her early care-giving environment; nevertheless, in exploring the focus question of the borderline's turbulently experienced object of

desire, I concentrate less on the self as the *recipient* of empathy, and more on the capacity of the self to be a *giver* of empathy.

In order to locate the illustrative material of Chapter Five within the theoretical focus, I have chosen to integrate the discussion of the sessional material alongside and together with the excerpts from the therapy sessions. In particular I have used theoretical explorations of the importance of processes of mutual recognition, and, paradoxically, the processes of destruction and *mis*recognition, to shed more light on the patient's idiosyncratic development of noxious distortions of recognition, both in her outside enactments and within the therapeutic hour.

In Chapter Six, I suggest that the therapeutic impasse occasioned by these stalemating enactments - an impasse experienced as profoundly uncreative by myself - led eventually to an understanding of the patient's experience of 'deadness', and thus pointed to the way in which an intersubjective aliveness might be brought back into the therapy. I look at the necessity for using the countertransference directly and indirectly for progress in the analytic space with difficult patients, and the necessity for the therapist to process the patient's indigestible projections in order to offer new ways of re-internalising and handling feelings that were previously projected.

CHAPTER TWO

THEORETICAL BASIS AND THE RELEVANT LITERATURE

I have developed my understanding of the developmental deficiencies leading to Borderline Personality Disorder within a psychoanalytic tradition that draws on object relations and self psychology and have gone on to explore the concept of the development of mutual recognition and the capacity for empathy from a relational perspective within evolving intersubjectivist theories.

I have located the deficits in the structure of the self associated with Borderline Personality Disorder in the rapprochement subphase as described by Mahler and her colleagues' (Mahler, Pine and Bergman, 1975). Mahler et al.'s developmental theory traces how the infant emerges psychologically from an undifferentiated symbiotic fusion with the mother to develop an increasingly separate and differentiated self. Mahler described three developmental phases: normal autism, normal symbiosis and separation and individuation. There is considerable overlapping between these different stages, and the separation-individuation stage is conceptualised as having four subphases. Arising out of Mahler's studies on borderline phenomena (Mahler, 1971), the borderline's ongoing dilemmas involving fear of engulfment and terror of abandonment are located in this latter separation-individuation phase of psychological development.

Bowlby's (1977) suggestion that early experience with the caregiver is the basis for the organisation of later attachment has been widely cited in explanations of psychopathology in the presentations of Borderline Personality Disorder (in Fonagy, Target, Gergely, Allen and Bateman, 2003). Over the last four decades since Bowlby's original notion that optimal self-development takes place in a secure attachment context, mother-infant research has mapped the intricate process whereby the mother (or caregiver), through facial and vocal mirroring, and through playful interactions, gives form and meaning to the baby's affective and intentional states. The mother's recognition plays a central role in modulating overwhelming affective states for her baby, and provides the secure platform for an increasing sense of agency in the baby. At the same time, this research has drawn attention to the less obvious role that the baby's

recognition of the mother has on her optimal levels of responsiveness (cited in Mitchell, 1990). Extensive mother-infant research has shown how vital this relationship of mutual influence is for self-development and how this relationship eventually allows the child to form the psychic representations that are at the heart of his/her developing selfhood (Fonagy et al, 2003).

Therapies with patients who present with borderline features are notorious for the ideational confusion and affective disturbance they engender in the therapist, and accordingly I have been drawn to those theorists who have developed coherent arguments within the 'intersubjective turn' in psychoanalysis that allow for "a way of processing the analytic encounter that can serve as the third position or point of reference outside the dyad as a position from which to reflect" (Gerhardt, Sweetnam and Borton, 2000, 10(1) p.10). I have drawn particularly on Christopher Bollas and Jessica Benjamin's theories, as their theoretical engagement with issues of subjectivity is both coherent and rigorous. Both Benjamin's emphasis on the development of empathy, and Bollas's discussion of techniques to do with countertransference and self-disclosure are attractive because they speak to the task of engaging with difficult patients.

Early self psychology's focus on the self as primarily the recipient and not the giver of empathy, and on the selfobject as primarily the stabilizer of the self, has largely meant that 'the other' has struggled to find a clearly articulated place in the theories (Benjamin (1990) as cited in Mitchell, 1993). It has been within the evolving intersubjective theories that an articulated place for the 'outside' other has been elaborated, and I have drawn on these theories for understanding some of the intricate processes involved in the incapacity to 'recognise', and for my understanding of the role of mutual recognition. Nevertheless, intersubjectivity theory as outlined by Stolorow, Brandschaft & Atwood (1987) - perhaps the best known proponents of intersubjectivity theory - does not provide a developmental perspective, nor does it distinguish subject-object relations from intersubjective ones (Mitchell, 1993). Accordingly, I have located disturbed patients' difficulties with experiencing *pleasure* in the reciprocity of mutual recognition within Jessica Benjamin's relational theory. Her developmental theory emphasizes intersubjectivity as a developmental achievement that "unfolds through key moments of transformation" (Mitchell 1993, p.188).

At its most simple, the manifest suffering of borderline personality disordered individuals arises out of a seeming inability to adapt to the ways of the world. In the predominantly paranoid borderline presentation that is the focus of this case-study, I have been interested to track the

lack of empathic connectedness that in my patient took the form of a triumphant refusal to recognise or acknowledge the perceptions of others. This in turn has led me to narrow my focus on one particular area of developmental achievement, that of the capacity to attribute mental states to others which arises in the context of the gradual integration of the "pretend and psychic equivalent modes of functioning" (Fonagy et al., 2003, p 449). This capacity is greatly facilitated by secure attachments that arise out of the optimally playful parent-child relationships in which,

> ...feelings and thoughts, wishes and beliefs can be experienced by the child as significant and respected on the one hand, but on the other as not being of the same order as physical reality. Both the pretend mode and the psychic equivalent modes of functioning are modified by the interaction with the parent... (Fonagy et al., 2003, p.449).

Many of the difficulties that more disturbed borderline patients have with regard to mutual recognition point to aberrant caregiver-infant interactions in the rapprochement subphase of the separation-individuation phase (Mahler et al. 1975), but also indicate affective malattunements at both earlier and later stages of development. Borderline difficulties suggest a pervasive and ongoing failure of conditions within the caretaker-infant relationship to create the conditions for a flexible and continuous sense of self; a self with a capacity for empathy.

Transitional phenomena

For Winnicott the conditions for creating such a self was first crystallised "in the matrix of a disillusioning relationship" (Macaskill, 1982, p.305) with the mother, and only the successful negotiation of the disillusionment in this relationship could provide the later capacity to be playful, to live creatively and to authentically express one's deepest feelings. In his theory of 'transitional phenomena', Winnicott (1974) assumed that the infant's early self-absorbed manipulation of objects in hand-to-mouth behaviour (such as caressing and sucking a corner of a blanket) represented a mode of experiencing that was transitional between the earliest stage of total subjectivity and unawareness of external reality, and a later stage where there was an awareness, recognition and acceptance of objective external reality. He suggested that the later equivalents of the infant's transitional phenomena were only accessible if the infant had during this earlier stage been 'held' in an enabling relationship with the mother, and where the mother's sustained empathic responsiveness had allowed for the gradual introduction by her of her own increasing need for separateness. In this process, the infant perceives these introductions of

separateness by the mother as failures of empathy, but they can be tolerated where she sustains a supportive stance, such that the growing child is supported to accept the conditions of relatedness and separateness that external reality imposes (Macaskill, 1982).

The transitional space

The transitional space as proposed by Winnicott conceptualises a comforting, reassuring experience that allows the infant to grapple with and transcend the existential anxieties that arise in the course of the disillusionments occasioned by the developing and maturing mother-infant relationship. Winnicott (1974) viewed this mode of experiencing as an 'intermediate' area where the infant perceived objects neither completely subjectively nor objectively and could entertain 'the perpetual human task of keeping inner and outer reality separate yet interrelated' (as cited in Macaskill, 1982, p.350). This mode of experiencing is seen as highly adaptive for the infant and, more importantly, continues throughout life as a counterpoint to intrapsychically dominating, inflexible forms of object-relating, in that the individual draws on the understandings and experiences of this intermediate area to later express his or her most creative self in play, art, religion and other cultural activities.

The transitional mode of experience and the development of empathy

Winnicott's concept of transitional phenomena is useful for understanding the failure of disturbed patients to connect not only with the therapist, but also with others in ways that are playful, creative and empathic. Winnicott stressed that,

> The crucial element for the effective functioning of these transitional phenomena was that, although they might be only subjectively true or meaningful, they must be respected by the mother ('a paradox to be accepted and tolerated and respected, and for it not to be resolved', p xii, Winnicott, 1974)" (as cited in Macaskill, 1982, p.351).

This concords with Bollas's suggestion that individuals characterised by disturbed patterns of interrelating may in early childhood have had the powerful illusion shattered that the mother "knows them from within" - by her refusal to engage in 'essential early play' or 'creative misperception' (Bollas, 1992, p.190). Winnicott (1974) himself suggested in his paper on *Playing and Reality* that ruptures in the transitional relationship in its early stages "further undermined the borderline's adaptive capacity by damaging his capacity to utilise and enjoy the protective

and creative functions of transitional phenomena and the transitional mode of experience" (as cited in Macaskill 1982, p.351).

The infant's engagement and connection with the mother as 'other'

Further strengthening research support for Winnicott's theories, the work of Beebe and Lachman, and Beebe, Lachman and Jaffe (in Brothers & Lewinberg, 1994) has established the process whereby caretaker and infant systematically affect, and are affected by each other, to be an important basis not only for the organisation of self-experience, but for the development of empathy as well. Benjamin believes that purely intrapsychic theories based on the importance of the self-experience do not adequately describe what it is in the mutual interaction of caregiver and child that accounts for the development in the child of the capacity for empathy, playfulness and creativity. In particular she argues that separation-individuation theory "leaves the aspects of engagement, connection, and active assertion that occur with the mother as other in the unexamined background" (in Mitchell, 1990, p.186). She goes on to suggest an uneven but continuous development of intersubjectivity in which there are "key moments of transformation". (Ibid. p.188)

Mutual Recognition

Benjamin's contribution to the intersubjective turn in psycholanalysis has been to elaborate it in terms of the concept of 'mutual recognition'. Mutual recognition refers not only to the self's need for recognition from the other, but to the need to recognise that the other is a subject too, a subject that is equivalent yet different from the self. Essentially Benjamin is arguing for a theory that goes beyond the subject-object relational field and into the subject-subject relational field. She critiques infantocentric theories for not elaborating this very important aspect of the child's evolving capacity for recognition,

> Where is the theory that tracks the development of the child's responsiveness, empathy and concern, and not just the parent's sufficiency or failure? At what point does (the responsiveness of the selfobject) become the responsiveness of the outside other whom we love? (Ibid. 1990, p.187)

Benjamin offers a theory of recognition that uses Stern's theory of phases of increasingly differentiated affective attunement to further develop Mahler et al's (1985) separation-individuation theory. She argues that while the latter stresses separation issues (at the differentiation and practicing subphases), and the former stresses affective attunement and an enhanced felt connection between mother and child, the two theories are not mutually exclusive but in fact complementary (Ibid. p.189). Benjamin argues convincingly that that there is *both* connection *and* separation happening - a balancing act occurring between the child asserting itself, while continously engaging with the process of recognising the other.

The crisis of mutual recognition

In Benjamin's theory, the rapprochement phase remains crucial, and is fraught with very real tensions. Benjamin characterises the demands of this phase as posing a "crisis" for the development of mutual recognition (Ibid. p 191). The crisis is embedded in the fact that the mother must both set limits for the child as well as recognise the child's will. The child must balance even more complex tensions, such that,

> The need for recognition entails this fundamental paradox: in the very moment of realising our own independent will, we are dependent upon another to recognise it. At the very moment we come to understanding the meaning of I, myself, we are forced to see the limitations of that self. At the moment when we understand that separate minds can share similar feelings, we begin to find out that these minds can also disagree. (Ibid. p.191)

The borderline patient's oft-noted oscillation between the fear of engulfment and the terror of abandonment, between preoccupied clinging and then disorganised fragmentation, can be understood to arise out of and to reflect the unsuccessful negotiation of the crisis of mutual recognition that is embedded in the tensions of the rapprochement phase.

Benjamin argues that Mahler et al's description of rapprochement has underestimated the crisis, and consequently set the aims of development too 'low' (Ibid. p.191). In their theory, the rapprochement conflict is resolved through the internalisation of object constancy and the child is then able to separate from the mother but is able to still access her good presence even when feeling angry with her. Benjamin suggests that this 'sparse' formulation does not sufficiently explain how the development of mutual recognition has been promoted,

> In this picture, the child has only to accept mother's disappointing her; she does not begin to shift her center of gravity to recognise that mother does this because she has her own center. (Ibid. p.191)

The ongoing nature of the tensions involved in mutual recognition

From Benjamin's standpoint however, the rapprochement 'crisis' is not so much resolved as it is continuously tested. The tension between asserting one's own inner reality and accepting the outside reality of the other can be held or juggled or balanced, and it may also breakdown, and need to be constantly *re*created. Benjamin argues that theories that concentrate on the processes of either internalisation or self structure building have obscured the 'satisfying' tension that destruction and its survival entails.

Destruction and survival in the process of discovering the other

Applying Winnicott's concept of 'destroying the object' to Mahler's rapprochement crisis, Benjamin highlights the way in which the basic tension between denial and affirmation of the other, between omnipotence and the recognition of reality needs to be sustained for optimal psychological development to occur. Winnicott's (1969) account of the changeover from 'relating' to objects to the 'use' of objects is not therefore automatic but depends on the facilitating object, the mother. The self is first made real through recognition by the mother, and the object is first made real through destruction by the infant (Winnicott in Phillips, p.131). She stresses that Winnicott's notions of destruction and survival are best viewed not only as power struggles, but are also the crucial enablers of a capacity to discover the other, a capacity that is far more remarkable in psychological and human terms than the mere internalisation of mental products,

> The collision that Winnicott (1971) has in mind, however, is not one in which aggression occurs "reactive to the encounter with the reality principle", but one in which aggression "creates the quality of externality" (p.110). When the destructiveness damages neither the parent nor the self, external reality comes into view as a sharp, distinct contrast to the inner fantasy world. The outcome of this process is not simply reparation or restoration of the good object, but love, the sense of discovering the other. (Mitchell, 1990, p.110)

The necessity for the complementarity of the intrapsychic and the intersubjective

In situations where the other does not 'survive' the child's destructive attack – whether that means that they give in to its omnipotent absolute self, or whether they obliterate it with their own anger and hate, a process of internalisation takes place in order to try and get rid of the bad feeling that cannot be worked through with the outside other and dissipated. Benjamin stresses that internalisation *per se* is not a problem, (and may indeed even be seen as a 'constant symbolic digestion process' and part of the important exchange between the individual and the outside), but rather it is the *inequivalence* between the intrapsychic and the intersubjective that is problematic. The complementarity of the intrapsychic and intersubjective modalities explains why Winnicott's notion of the 'reality of survival' in contrast to the 'fantasy of destruction' engenders something beyond mere internalisation, something pleasurable;

> This reality principle does not represent a detour to wish fulfilment, a modification of the pleasure principle. *Nor is it the acceptance of a false life of adaptation* (my italics). Rather it is continuation under more complex conditions of the infant's original fascination with and love of what is outside, his appreciation of difference and novelty. This appreciation is the element in differentiation that gives separation its positive, rather than simply hostile colouring: love of the world, not merely leaving or distance from mother. To the extent that mother herself is placed outside, she can be loved; separation is then truly the other side of connection to the other. (Ibid. p. 193)

Under these optimal conditions the true self feels creative, authentic, alive, real and spontaneous.

The development of the false self

I would like to track the acceptance of a "false life of adaptation" italicised above and look at it as the default option for the child who does not manage to go beyond defensive internalisation processes. In Winnicott's formulation, the false self develops at the earliest stage of object relations where there is not "good-enough" mothering, and where the mother cannot meet and implement the omnipotence of the infant. When the mother is not robust enough to survive the infant's destructive attack, she is experienced as rejecting in ways that force the experiencing infant to become compliant. These compliant strategies are what organise the development of

a false self. The false self therefore develops out of a defensive need to meet the needs of the mother. In addition, this false self hides the true self which Winnicott conceptualised as having authentic, creative, original ways of being. The false self, reacting compliantly to environmental demands, is unable to engage genuinely in relationships with others, with the result that the person organised by the false self feels at best unreal and at worst futile.

Degrees of false self

Phillips notes that Winnicott conceived of many 'degrees' of false self (cited in Phillips, 1988, p.134). I want to briefly add to this notion of 'degrees' of false self, that adult enactments such as 'violent innocence' (Bollas 1992) may reflect the inadequately parented self's attempt to use transitional phenomena to negotiate the difficulties experienced with the mutual exchange of separateness and contingency. Bollas's notion of the "violent innocent" situates the experience of it (by both the recipient and the enactor) at the 'intermediate' border of external provocation and internal disturbance.

The compliant self and the 'innocent' self

Phillips also notes that Winnicott, "in a characteristically oblique sentence" suggests that the false self may even enact a role of the true self "as it would be if it had had an existence" (Phillips 1988, p.136). This may point to the way in which the angry false self faced with the paradoxical aspects of balancing what Bollas calls "the dense logics of deception" (1992, p.189) involved in mutual recognition may find a way to resist through violent innocence. We could perhaps conceptualise this as the 'compliance' of the infant metamorphosing into the 'innocence' of the adult.

The value of the countertransference for intersubjectivity

Bollas's writings (1987, 1992) explore the conscious and unconscious processes in the psychoanalytic encounter that highlight the clinical value of being alert to intersubjective processes that are created by transference-countertransference material. This alertness is not a strained vigilance, but the creating and maintaining of an 'amiable' receptivity for the use of unconscious processes in order to locate the patient's disavowed psychic material (Gerhardt and Sweetnam 2001, p.48). Bollas views the countertransference as not merely as a subjective

process, but as an intersubjective encounter in which the analyst must become fully immersed over undisclosed periods of time before " he can begin to identify with it, think it through, and finally speak from within it." (Ibid. p.53)

The expanded value and role of the countertransference

Bollas's formulation of the value of the countertransference is a radically receptive one, and reflects his commitment to an intersubjectivist position within current debates in psychoanalysis. Over the last century, the value of the countertransference experience inside the clinical hour has assumed a more inclusive role than Freud's original concept of it as a "technical error" on the part of the therapist (Dunn 1995, p.726). This expanded role has occurred not least in response to psychoanalysts having to come to terms with intense countertransference reactions to patients with far more severe psychopathologies than were seen in Freud's day (Ibid. p.727).

The borderline object of attachment

Bollas (1999) suggests that the borderline patient's experience of early interpersonal provocation, indifference (or neglect) and abandonment, leads not only to perceptions of current relationships as disturbing and attacking, but even to a paradoxical need to recreate the turbulence of this early relationship. The borderline object of attachment,

> ...is the deeply disturbing emotional wake of the other which includes the fright, rage and destructive hate aroused within the borderline self, a persecutory anguish that further binds the self and its affective object in a psychically indistinguishable combat of negative forces. (Bollas 1999, p.129-130)

Outside of this turbulently experienced primary object, borderline individuals form

> ...objects outside the dominating realm of the primary state. Such objects bear the character of false self work, constructions brought together in a fragile and deliberate way – an avoidance of an essential truth. (Ibid. p.129)

In Bollas's notion of the 'violent innocent', the violent innocent mounts deliberate attacks against others that are publicly denied as amounting to attacks, and that can indeed be viewed as the "avoidance of an essential truth" referred to above. When those who are attacked eventually attempt to "out" the attack, violent innocents affect a 'radical' innocence;

> Clearly it is a form of denial but one in which we observe not the nature of the subject's denial of external perception, but the subject's denial of the other's perception...The violent innocent sponsors affective and ideational confusion in the other, which he then disavows any knowledge of – this being the true violation. (1992, p.180 -181)

The paradoxical illusion of understanding and the freedom to misperceive in mutual recognition

Bollas draws on Winnicott's notion that the mother facilitates her infant's illusion that it shapes the world out of its own needs and wishes, and he maintains that a similar illusion is sustained by a common "language" that enables us to assume that what we mean when we speak is what the other understands through our speech – but maintains that this is nevertheless an illusion. The beauty of the assumption that we are received and comprehended, is that it facilitates communication and creativity, and is a kind of "freedom", albeit a paradoxical freedom,

> Because we do not comprehend one another (in the discreet, momentous conveying of the contents of our internal world) we are therefore free to invent one another. We change one another. We create and re-create, form and break our "senses" or "understandings" of one another, secured from anxiety or despair by the illusion of understanding and yet freed from its impossibility to imagine one another. This is, I suggest, a double paradox. Because we do not comprehend one another, we are free to misperceive – an act of creativity – and so, out of this gap emerges unconscious mental life, or intersubjective play, which brings us closer together. (1992, p.186)

The necessity for misrecognition and disillusionment in mutual recognition

This echoes Benjamin's elaboration of the positive outcome of the path to separation, where she talks of " the *pleasure* of the evolving relationship with a partner from whom one knows how to elicit a response, but whose responses are not entirely predictable and assimilable to internal fantasy" (1990, p.187). Benjamin is dealing with the paradox of 'destruction' as the necessary foundation for mutual recognition, and Bollas is stressing the paradox involved in the necessity of 'misrecognition' in the interests of ongoing communication. The link between these two paradoxes is that they themselves are intimately founded on Winnicott's paradox of

the necessity of 'disillusionment' for creation of the authentic and flexible self. We have merely to look at these paradoxes of recognition, involving as they do the necessity of destruction, misrecognition and disillusionment to understand why Bollas has brilliantly conceptualised these ostensibly inauspicious foundations as part of 'the dense logics of deception' that are involved in recognition (1992, p.189).

Violent innocence as transitional phenomena for the false self

I want to argue that in an individual devoid of the experiences that lead to the achievement of mutual recognition - one who is thereby forced to fall back on an acceptance of a false and compliant life of adaptation - acts of violent innocence may be an attempt at interrelating that "gets" the deception, but not the logic of it, i.e. may be an attempt to make use of transitional phenomena such as the perverse pleasure to be gained from disavowal of aggression. Disavowal of the other's perception then consigns the recipient to "an intense lonesomeness, where feelings, thoughts and potential verbalisations have no reception. Here the recipient sits at a doorway, between intrapsychic and intersubjective existence" (Bollas 1992, p. 181). The repudiation and disavowal involved in violent innocence may then reflect the perpetrators repetition of maternal hatred against the self, where instead of the tension between the intrapsychic and the intersubjective being sustained in tolerable ways, the infant / child's subjective meanings and truths were challenged in ways that impinged and provoked.

Repetition of the maternal object in violent innocence and borderline sensationalism

Whereas Bollas (1992) does not place 'violent innocence' as solely a borderline enactment, he argues in a separate work (1999) that "borderline sensationalism" - the mixture of rage and mental pain that characterise the borderline's emotional outbursts - may be seen as the borderline's attempt to cohere the self, and to avoid going to pieces while falling apart, as it were. However offending this turbulently experienced primary object is in its visitations, the borderline nevertheless also experiences deep desire for it as Benjamin's "dreaded but tempting object" (1990, p.197), and as Bollas's, "profoundly familiar other who inhabits the self and becomes indistinguishable from it ... an awful truth that is at the very essence of the formation of the self" (1999, p.134).

Unwitting therapeutic support for the false self

The formulation this provides is stark: turmoil is the presence of the object, quiescence is abandonment by the object. Bollas refers to the clinical difficulties this poses for the therapist,

> It is unfortunate that many well-intentioned therapeutic endeavours designed to get the borderline patient to understand and use boundaries, find socially appropriate expressions, and adapt to their surroundings, *often support this person's false self* (my italics). Here the false self is a move to be without affect and to avoid engagements that will stir up the self ... Unsurprisingly, the analysts good enough technique is often experienced as strangely depriving, seemingly preventing such feeds, so misunderstanding may be sought in order to gorge the self on disturbed states of mind. (Bollas, 1999, p.133)

The use of sensational affect to communicate

Putting boundaries in place in the therapeutic hour, and supporting adaptations so as not to be stirred up by others in the outside world, effectively removes the emotional outbursts that the borderline patient needs to experience the presence of the primary object. If the therapist can get past the confusion that such patients evoke, then one can begin to see how and what is being communicated. Borderline patients find it hard to verbally beat about the bush. Because they do not have the language for integrating thoughts and feelings, they act countertransferentially on therapists and others, "using affect, in an autistic-somatic way, for its sensational effect, rather than for its communicative function" (Bollas, 1999, p.132) while appearing themselves to be immune to affect. Determined not to be stirred up, such patients 'innocent' false selves may became forensically determined to demand unambiguous clarity, insisting on " the militant presence of a fine-print mentality" (Ibid. p.191). However, as Bollas points out,

> ...the urge to ensure exact understanding would either paralyse the playful creation of one another or lead to a formalisation of exchange that expels misunderstanding as it legalises the exchange of thought. (1992, p.189)

The situational illness of the therapist

Both these paradoxical processes – the necessity of surviving destruction, and the necessity for creative misperception, were very helpful in deconstructing the negative countertransference that I reached in the long-term therapy with a borderline patient, and in establishing "a mental neutrality akin to the creation of an internal potential space" (Bollas 1987. p.201). Bollas has articulated how deeply disturbing and the unpleasant it is to feel that one is not being therapeutic, and terms this the 'situational illness of the analyst', but he goes on to argue that the countertransference in which these feelings arise, may be used as a kind of eventual code-breaker for whatever transference information the patient is attempting to articulate,

> This is so because the patient cannot express his conflict in words, so the full articulation of pre-verbal transference evolves in the analyst's countertransference. The transference-counter-transference interaction, then, is an expression of the unthought known. The patient knows the object-setting through which he developed, and it is a part of him, but it has yet to be thought. (1987, p. 230)

The implication of this is that if the therapy with the patient feels blocked, or if one's analytic tools are rendered useless, one needs to explore the particular form that the transference-countertransference discourse is taking, in particular "the troublesome impingements" of one's own judgements. (Ibid. p.201)

Forms of aliveness and deadness in the therapy

Ogden's clinical suggestions with regard to analysing these forms of aliveness and deadness in the transference-countertransference include asking questions about what sort of "substitute formations" might be masking the "lifelessness of the analysis" (Ogden 1995, p.695), and he provides one such example as being "perverse pleasure". Paranoid borderline patients seem to enjoy the "fury of the self's persecutory force" (Bollas, 1999, p. 130), which, once evoked, may assume a projective life of its own, expressing itself as a hungry paranoia, keen for insult and injury. Bollas has variously described these substitute formations as attempts at communication and intimacy, "an attempt to break bread in the communion of turbulence" (Ibid. p.130) and, "an attempt at intimacy, even if it is achieved through cruelty and suffering" (Ibid. p.

138). This is a helpful reminder, because borderline and paranoid attacks usurp one's own inner world in ways that make it difficult to see that behind the unpleasant vividness and "aliveness" of these attacks, there lies emptiness. Where this emptiness is linked to the inability to negotiate a sense of shared reality, despair - and not pleasure - informs the behaviour,

> Such states are not conjured up in order to give pleasure, but because the paranoid patient feels split between a false self replete with phoney representations and a real self composed of pain that derives from the gap, the difference, between a potentially good inner world and a desperately false representational order. (Bollas 1999, p. 138)

Sustaining the contradiction between fantasy and reality

Winnicott's concept of the "potential space" has allowed for exploration of how the child establishes a distinction between the symbol and the symbolised. This potential space facilitates a distinction between a real other and a symbolic other, and is an important precondition for sustaining the contradiction between fantasy and reality that is so necessary in recognising 'otherness' (Benjamin 1990, p.198-99). Where the primary object's omnipotence is not modified and counterbalanced by differentiation, then omnipotence, grandiosity and envy become the pretenders to the throne - or as Benjamin puts it, "the lack of intersubjectivity in this psychic situation can be conceptualised as the assimilation of the subject to the object" (1990, p.196).

Omnipotence as a saboteur in the potential space

Quite apart from its manifestation in the characterologically disturbed patient's unhappy adaptation to the world, omnipotence raises clinical problems for the therapist. The concept of a potential space has application to both the exploration of omnipotence and the analytic process,

> What we find in the good hour is a momentary balance between intrapsychic and intersubjectve dimensions, a sustained tension or rapid movement between the patient's experience of us inner material and as the recognising other. This suspension of the conflict between the two experiences reflects the successful establishment of a transitional

> space in which the otherness of the analyst can be ignored as well as recognised. The experience of a space that allows both creative exploration within omnipotence and acknowledgement of an understanding other is, in part, what is therapeutic about the relationship. (Benjamin 1990, p.198)

Giovaccini (1989) suggests that where patients cannot respond to approaches designed to support an observing self, there is a corresponding tendency in the therapist to offer "a constructive therapeutic experience rather than an analytic one" (Ibid. p.245). He also refers to the problem that omnipotence poses for therapists - for the borderline patient whose ego states shift confusingly between what is 'inside' and what is 'outside', interpretations are often seen as either an attempt to rob them of their fragile autonomy, or paradoxically, as a threat to the symbiotic fusion they create with the idealised therapist (1989, p.234). Like Benjamin, he identifies this as the assimilation of the subject to the object, such that he describes the reactions of his own patient thus,

> If I made an observation about our relationship, it indicated that a relationship between *two* people existed... Furthermore, the atmosphere of magical omnipotence seemed to be disturbed by a transference interpretation. To remain a deity one must stay concealed; gods do not reveal themselves if they are to preserve their omnipotence. (1989, p. 234)

Giovaccini argues that such patients do not want to give up their symptoms, but seek only to have their defences reinforced in order to feel more comfortable with false self adaptations (1989, p.236).

Intersubjective conjunction and intersubjective dysjunction

Giovaccini's analysis of magical omnipotence rings all too true, nevertheless therapeutic impasses can be more usefully located in the intersubjectivists' notion of the continual *interplay* between the patient's and the therapist's worlds. Stolorow et al note that "intersubjective conjunction and intersubjective disjunction" (1995, p.397) are situations that arise continually in therapy, and they put greater onus on the therapist to become reflectively aware of the principles that unconsciously organise their own, as well as their patients' experiences. Exacerbations of patients' psychopathology are seen to occur most frequently when the therapist misunderstands the patient's emotional needs,

> Such misunderstandings typically take the form of erroneously interpreting the revival of an unmet developmental longing as if it were an expression of malignant, pathological resistance (1992, p 103).

Inevitably this raises the question of what role the therapist's own organising principles are playing, and his or her capacity to be not only aware of these, but able also to reflect continuously on their interplay with the patient's organising principles.

The use of the therapist as a transformational object

In contrast, Bollas urges the therapist to use him/herself as a transformational object, to allow the unmet developmental longing to find expression through him/her in the therapy. The task is for the therapist to endeavour to find a language for the "as-yet-inarticulate" perceptions of potential significance that s/he registers as a mere sensing, or a feeling state, or even an unidentified disturbance, and furthermore to offer these to the patient for mutual consideration. This echoes the interactions in the early maternal dyad, where the infant's pre-verbal being requires,

> ...maternal perception (often achieved through a kind of instinctual knowing), reception (a willingness to live with the infant utterance), transformation into some form of representation, and possibly some resolution (the ending of distress). (1987, p.235)

Bollas's suggestions invite a radical use of the countertransference material; a messy entertainment of instinct, sensing, apprehension and perception that is a far cry from the crisp and economical delivery of interpretation employed by classical psychoanalysis. Nevertheless, the implication seems to be that if we can tolerate this messiness then paradoxically we may enter a reverie that rigorously 'fine-tunes' our sensibility to our patient's unmet developmental longings, just as the "good enough" mother's reverie might.

CHAPTER THREE

THE QUALITATIVE CASE STUDY AS METHODOLOGY

Therapy involves empathic immersion into the patient's inner world via close personal interaction, and in agreement with a considerable body of contemporary social researchers (Henwood and Pidgeon, Lincoln and Guba, Stake, Donmoyer in Hammersley and Gomm, 2000), I see the individual case study as the research tool of choice for clinical psychologists. This is partly due to the fact that, "the process of psychoanalytic understanding involves taking empathic risks and testing hypotheses in dialogue with patients in ways that make possible new, more complex meanings" (Orange, 1995, p.72), a process which echoes that of testing hypotheses in research. However, testing hypotheses is not its most useful value – rather, the case study allows researchers to assess and understand the sessional 'data' of the analytic encounter in ways which I believe can be most useful for psychology's experiential aims - not useful in the more traditional terms of generalisability, but useful more in terms of a vicarious transferability.

The case study as naturalistic generalisation

Stake terms this kind of knowledge "naturalistic generalisation", which, unlike scientific induction, "is arrived at by recognising the similarities of objects in and out of context and sensing the natural covariations of happenings." (in Hammersley & Gomm, 2000, p.22). This notion of natural covariation, rather than that of aggregates, seems better suited to the empathic and respectful understanding of the whole individual at which the psychoanalytic realm strives. The case study 's narrative method more readily supports ways in which the clinical subject may be literally 'author'-ised to speak.

The case study as enriching humanistic understandings

Far from being limited to the gathering of individual and discrete information, the case study also adds to "existing experience and humanistic understandings", and Stake argues that this may be its most valuable asset as a methodology (1990, p.24). As psychologists, we are not immune from attempts at total explanations, but individual case studies enrich our humanistic understanding by

taking account of the fuller complexity of human phenomena, releasing us from the more reductionist paradigms that have tended to dominate the human science disciplines with a disproportionate and often ideologically informed 'authority'.

The value of being alert to the indeterminate, the idiosyncratic and the irrational

The good clinical case study obliges us to be alert to what is not only indeterminate or idiosyncratic about ourselves and our patient as well as the prevalence of the irrational, but, also challenges us to be alert to our own personal historicities, or to what might possibly be erased about others' subjectivity. In South Africa, we need to be alert to the intrusion into our own clinical orientation of hegemonic Northern Hemisphere notions of what constitutes academically sound frameworks. This is a requirement to be alert to the "associative matrix not of our making" - a commitment to recognising where 'Othering' might be implicated, and where "difference and deafness" might be obscured (Swartz 2004, p.12). The individual clinical case study can therefore allow for the detail of narrow experiences to proliferate into expanded understandings.

The concept of generalisability

The qualitative methodology emerges out of a distinct research paradigm that has different assumptions about how the world can and can not be studied and one which critically assesses the ways in which traditional notions of generalisability may hinder rather than help our enquiries. This newer paradigm queries the objectivist view that the role of research - whether in physical science or in social science - is to discover and validate generalisations about lawful regularities that exist between cause and effect. One criticism of the traditional model is that it actively interferes with our role as social scientists;

> The argument can be stated simply: social scientists' traditional restricted conception of generalizability is consistent with traditional views of applied social science but inconsistent with more contemporary views. Furthermore the traditional restricted conception is not only out of sync with contemporary epistemology; it is also dysfunctional because it limits our ability to reconceptualize the role social science might play in applied fields such as education, counselling and social work. (Donmeyer, 2000, cited in Hammersley & Gomm, 2000, p 47).

Lincoln and Guba (Ibid p.46) criticise the inadequacy of generalisability for researchers who are particularly interested in individuals, and Donmeyer queries whether thinking about generalisability, "solely in terms of sampling or statistical significance is defensible or functional" (Ibid. p.66).

The attempt by the empirical sciences to eliminate subjectivity through what Roszak famously termed the 'the myth of total objectivity' has been seen as having failed to address the concerns of a post-modern worldview, more particularly to address the ideological aspect of its own claims to autonomy and objectivity. As Lather (Ibid. 2000) and other anti-positivists and critics have pointed out, research *is* ideological; it inevitably conceals even as it reveals.

The requirements of a contemporary research epistemology

This paradigm shift has raised questions about a preferable epistemology. What kind of research would then be adequate, functional and defensible if we are primarily interested in thinking about individuals? What *would* be 'in sync' with contemporary research epistemology? Freedman and Coombes (1996) have answered some of these queries by locating contemporary research in a post-modern worldview. They simplify this worldview as being one as one in which reality is broadly held to be (a) socially constructed (b) constituted through language (c) organised and maintained through narrative, and (d) in which there are no essential truths (Freedman & Coombs, 1996).

Critiques of mainstream psychology

Within psychological enquiry, discourse analysis has staked claims to a paradigm shift along very similar lines, but argue that theirs is an analysis that moves beyond debate around methodologies; rather,

> It is a critique of mainstream psychology, it provides an alternative way of conceptualising language, and it indicates a method of data analysis that can tell us something about the social construction of social reality. (Creswell 1994, p.90)

Within contemporary psychology over the last decade, critiques of mainstream psychology have given rise to the paradigm known variously as *relational-model theorising* (Mitchell 1988), *dyadic systems perspective* (Beebe, Jaffe and Lachman, 1992) *social constructivism* (Hoffman 1991) or more commonly as *intersubjectivity theory* (Stolorow, Brandschaft and Atwood 1987), and this

critique has also undermined what has been characterised as intrapsychic determinism or 'the myth of the isolated mind' (Stolorow and Atwood 1992, p.129).

> The doctrine of the isolated mind in psychoanalysis has historically been associated with an objectivist epistemology. In contrast, the intersubjective viewpoint, emphasising the constitutive interplay between worlds of experience, leads inevitably to an epistemological stance that is best characterised as "perspectivalist". (Ibid. p.122)

The steady erosion of these two myths, 'the myth of objectivity', and 'the myth of the isolated mind' has radically altered the terrain of enquiry for social scientists;

> The central metaphor of the new psychoanalytic paradigm is the larger relational system or field in which psychological phenomena crystallise and in which experience is continually and mutually shaped...From the perspective of this new paradigm, the observer and his language are grasped as intrinsic to the observed. (Stolorow, 1995, p.393)

The concurrent and mutually organising activity of analyst and patient

Orange's perspective (1995) emphasises the concurrent and mutually organising activity of the analyst and patient, and, importantly, from the psychoanalytic point of view the importance of this for processing empathy and creative understanding. Only by testing our own organising principles in dialogue with our patients can new meanings be forged. This kind of dialogue is a radical departure from objectivist theories of truth, or the psychoanalytic focus on the subjectivity of the patient. This is a conversation, but an 'implicit' conversation between perspectives and thus it is not small talk. To the contrary, perspectival realism demands a rigorous vicarious introspection,

> In psychoanalytic language, we must know and acknowledge our cotransference, our point of view or perspective if we are to become capable of empathy...In order to do authentic psychoanalytic work, or to speak authentically of our work, we must acknowledge the lenses through which we are reading the text or the patient. (1995, p.68)

This perspective demands a high degree of idiosyncratic reflexivity and credibility, two criteria that Creswell (1994) cites as necessary for evaluating the kind of qualitative research that has been attempted in the methodology applied to this case study.

I have therefore located my analysis of this case study within this broad intersubjectivist field, more particularly with the relational theorists who share in this emphasis on the human mind as interactive, who understand the psychoanalytic process as occurring between subjects rather than within the individual, and who stress intersubjectivity as a developmental achievement.

The idiosyncratic nature of qualitative evaluation criteria

What kind of evaluation criteria for qualitative research might take the place that the criteria of generalisability holds for quantitative research? The difficulty is that quantitative criteria need to be almost as idiosyncratic as the methodologies themselves,

> As qualitative research arises out of very varied epistemological and ontological frameworks, some researchers (Madill et al; Reicher in Creswell, 1994, p.42) have suggested that since there is no such thing as a unified qualitative research paradigm, criteria for evaluating qualitative research needs to be tailored to fit the particular method they are meant to evaluate. (Creswell 1994, p.144)

Creswell however cites broad areas of consensus on criteria that require the following three guidelines to be met;

a) The systematic and clear presentation of analyses,

b) Analyses demonstrably grounded in the data, and,

c) Emphasis laid on issues of reflexivity, credibility and transferability.

The visceral aspect of experiential learning

I wish to take up one aspect of evaluation criteria, that of transferability, that I have found the most compelling in the choice of the case study as a research tool, and that is Donmeyer's (2000, in Gomm, Hammersley & Foster, Chapter Three, pp 45-68) emphasis on the experiential aspects of learning provided for by the case study methodology. Donmeyer's schema concept of generalisability picks up on an earlier assertion that the case-study can provide vicarious experience, but goes beyond other writings that stress the value of the case study in providing 'working hypotheses' for researchers, or for providing 'transferability' beyond the specific context in

which the data was generated. He suggests that these writings fail to do 'justice' to the process of experiential learning that is uniquely offered by the case-study method. He feels that they also inadequately represent the knowledge that is generated by the process of experiential learning,

> The sort of knowledge gained by experience is not purely intellectual. It is often affect laden. Generalization thought of in terms of transfer of working hypotheses fails to do justice to this visceral aspect of experiential learning. (Ibid. p. 57)

This affect laden, visceral aspect of experiential learning can be overwhelming, as every therapist knows. Donmeyer argues that the case study has heuristic value as a research tool precisely because it provides visceral understanding of what is an intensely experiential process. The therapist/researcher must analyse and act on the patient, as well as interact with and jointly construct meanings with the patient. This engenders a 'lived-in' aspect to the narrative form that the case study takes, as opposed to more 'scientific' forms,

> Both forms of understanding require symbolic mediation; it is just that the symbolic form we call narrative allows us to symbolise and hence think and communicate about certain aspects of experience better than does propositional language. (Ibid. p.64)

Donmeyer (Ibid. pp, 61-65) argues that the visceral nature of the case study is its real strength, providing the reader with three ready-made advantages;

(1) it increases accessibility to otherwise inaccessible knowledge,

(2) it enriches understanding by providing for the cognitive expansion that allows more gradual accommodation of the disturbingly novel, the idiosyncratic and the particular,

(3) And, by not requiring first-hand immersion in the 'affect-laden' soup, so to speak, it decreases defensiveness and resistance to learning.

Donmeyer's concept of how the case-study facilitates an alternative form of generalisation conceives of generalisation more in psychological terms than in those of statistical probability. For this reasons it can be said to resonate with the analytic process itself. In psychoanalytic terms, the process of experiencing another's world in a visceral way is recognised as an important analytic tool, "but one that often defies description. Bion talks of the 'strangeness and mystery' of being the

container of a patient's thoughts and feelings. Bollas talks about becoming 'situationally' ill, receptive to varying degrees of madness'" (Swartz, 2004, p.3).

The case study researcher as metaboliser and symboliser

It can be argued that the case-study researcher metabolises direct visceral experience for the reader in a similar way that the therapist seeks to metabolise developmental trauma for the patient. The therapist renders overwhelming unconscious material into tolerable insights such that the patient can then apply greater clarity and understanding to making better choices in close relationships and the outside world. The case-study researcher metabolises the often disturbing visceral impact of the irrational, unique and particular interactions of the patient. In a similar process to the one I will later explore in relation to my patient's difficulties, the case study researcher survives the visceral impact of the patient's destructive projections and introjections, and gives to the reader a symbolic form in which to integrate his/her thoughts *and* feelings about the learnings involved in this process. It is hopefully this symbolic narrative form that the reader can find valuable and useful for application within psychology and in the wider humanistic arena.

Background to the therapy

While undergoing training at the Child Guidance Clinic, trainee therapists may choose to carry over one of their clients from the academic year into their internship year. As the internship year offers the possibility of therapy that can go on until the end of the internship year, a rare possibility in the over-burdened public health sector, these clients become known as 'long-term' clients, although in ordinary psychoanalytic terms, the period in which they can utilise the offered therapy does not constitute a 'long' therapy. There are ethical considerations to this training which are discussed below. Trainee therapists are instructed in supervision to discuss the issue of termination thoroughly with the 'long-term' client to be, so that the *de facto* finiteness of the therapy, and the implications that this will have for a realistic, and acceptable treatment plan, are introduced into it from the start.

Chapter Four gives the Case History of the patient whose therapy is the subject of this thesis. As this history indicates, by the end of the first year, I was aware of my patient's diagnosis as characterologically disordered, yet despite having experienced turmoil engendered by her use of primitive defences, short-term gains had also been made in that time. She had responded well to supportive therapy, she had taken practical steps to ensure that her frequently disorganised and

violent behaviour was contained, and had appeared able to access pockets of grief and guilt that indicated at the very least some capacity for concern. I had emerged from the end of the short-term therapy with a sense of our mutual engagement in the therapy intact.

The Child Guidance Clinic

The first 22 sessions with my client were held during the M1 training year at the Child Guidance Centre, the on site training institute for Clinical Masters students attached to the University of Cape Town. Primarily a training facility, the Clinic also provides various psychological services to the larger Cape Town community – psychometric assessments, therapeutic intervention for children with learning or behavioural difficulties, individual child therapy; and family therapy or couple counselling for parents or families who form part of the holding environment for those children. Sessions are charged on a sliding scale according to income, and the clinic, while attached to university grounds, is conveniently sited on the main road so that it is easily accessible for poorer clients who have to travel in from outlying residential areas by taxi or train. Consequently, the Clinic is utilised largely by those who cannot afford private therapeutic interventions, although the University's health services also direct staff there.

Equally accessible from the main road and station, and also charging according to income, Groote Schuur Hospital is a public hospital providing emergency, in-patient and outpatient health and psychiatric services to the greater Cape Town metropolitan area. During the second year of the therapy, 35 sessions with my client were held in Groote Schuur's outpatients department for the duration of my internship year.

Obtaining the data

The sessions held at the Child Guidance Clinic were videotaped, and session notes were kept to further document the process, and as a guide to the issues, complications and features of note to discuss in supervision sessions. Supervision was provided by an allocated senior psychologist who guided me to note and explore both transference and countertransference issues that emerged from the material in order to heighten therapeutic understanding. During the internship year, the sessions were not videotaped, as the hospital was unable to provide video facilities. After discussion with the new supervisor, it was decided not to request to tape the sessions due to the client's already disturbed acting out occasioned by the adjustments of moving to a new system and a new venue.

Thus for the remaining 35 sessions, session notes only were kept – in brief for the hospital records, and more detailed psychodynamically oriented notes were kept for discussion in supervision. Sessions were scheduled weekly, but due to my client's frequent travels outside the country for appointments to do with her work, and some leave period taken by myself, there were some weeks where sessions were missed. Outside of work commitments, my client attended her sessions diligently, and, according to our contract, let me know as far in advance as possible when she would be unable to attend.

Ethical issues

There has been much debate over the century or so of psychoanalytic writing with regard to the ethics of writing up case studies, particularly with regard to getting informed consent from patients about using the material from sessions (Swartz 2004, p.8), and the near impossibility of doing this in ways that will not impact on the therapy itself. For the purposes of this thesis, and to ensure client confidentiality and anonymity, the names of my client and her son and relatives have been changed, and demographic details have been omitted or obscured where they might be identifiable. I have however remained respectful to the material itself, and am confident that the intersubjectivity has not been compromised.

At the start of therapy, the client was informed of the Clinic's status as a teaching and training facility, and advised that the material from sessions might be used to further psychological knowledge. She was advised of the videotaping, and of the one-way mirror, and asked if she minded either. She stated that she was used to being videotaped at the sessions of a previous treatment centre, and the two-way mirror there, and objected to neither. The first intake session at which these issues were raised was to take a history from her that would establish the context of her son's difficulties, and she was not herself immediately in the spotlight at that time. However when sessions with the son ended, we continued to use the same video room for sessions, and the sessions continued to be taped until the end of the year with her permission.

Detailed monitoring of the way in which the trainee therapist/ intern manages the case, both therapeutically and administratively are ensured by the allocation of senior psychologists to supervise the interns. This is to provide support and training to the intern, but also to ensure that professional standards, ethical considerations, and the client's best interests are upheld.

The process of reviewing the data

Faced with 57 hours of therapy, almost as many hours of supervision in which the material emerging from the therapy was discussed in depth, 22 videotapes, two case presentations on the case, a long essay and my own extensive notes on the therapy, the data pertaining to this case-study required an editing process itself worthy of a metabolising metaphor - given that what was *not* affect-laden was not necessarily unimportant, and what *was* affect-laden required further selection and elimination.

However it is in what Bollas terms the "intuitional dialectic of genera formation, where patient and analyst construct a new vision together" that the greatest amount of a priori metabolising took place. The therapist takes up "the very ingredients of unconscious life, the displacing logic of primary-process thought, the distorting effect of ego defense" (Bollas 1992, p.187) and renders their often disturbing visceral impact into meaning, but in order to do so, must first engage at the coal-face of the transference and countertransference between her/himself and the patient. In the intersubjective field, this coalface includes messages conveyed and perceived in often shocking ways, "mutual displacements, distortions, affective reciprocities, psychic gravitational attractions..." (Ibid. p.192).

These messages released only limited meanings over the period of the therapy, which I then needed to absorb and process, both in my own introspections and in supervision. Frequently I was particularly transferentially stirred up and disturbed by material that emerged in the sessions, and struggled to separate these shocks and aftershocks from my own inner states. I was unaware during that period of Bollas's calm advice,

> When this is true, the analyst must hold himself within these regressions, giving time to the other parts of his personality, so that the information being processed, part of the unthought known, can be worked upon by the parts of the analyst's personality that are still available to reflect on experience. (Bollas, 1999, p148)

Having 'metabolised' the material and rendered it into symbolic form, I believe that visceral processing of the experiential material is indeed a valuable exercise in naturalistic generalisation. It allows not only for other readers to gain from the process of naturalistic generalisation, but for oneself as the researcher too to identify otherwise disparate experiences, thoughts, behaviours and feelings - indeed even mysteries - as meaningful, and therefore applicable to other cases.

CHAPTER FOUR

THE CASE HISTORY

Referral process and background to the intake.

Deirdre (29), brought her son Seamus (4), to the Child Guidance Clinic in August 2002, giving as the reason for referral that her son was displaying 'angry behaviour' since his father's abandonment of the family six months previously, and that she felt Seamus needed help in achieving closure with the father's sudden departure. Seamus attended a pre-school and Deirdre was a data capturer in a small business. Seamus's father, Simon (34) had left the marriage in 2001 and had not seen either Seamus or his mother since, a period of about 11 months at the point where I first saw Deirdre and Seamus as intake patients. Seamus had a half-brother, Dane (14) and a half sister, Charla (9), who were the children from his father's first marriage, then living with their own mother. Seamus's father had apparently returned to his first wife and was once more living with her. Deirdre and Seamus lived in a flat and Deirdre was supporting the two of them without any financial support from her ex-husband. Deirdre's family lived in Durban, but as a result of several separate confrontations and subsequent ruptures, she had estranged herself from each one of her family members.

Family History

Deirdre was the eldest child in a family of three, all of whom were married adults with nominal autonomy living away from home and from their parents at the point that she came for therapy. There was a younger sister immediately after her, and a younger brother after her.

There was a mass of evidence pointing to the transgenerational transmission of abuse in Deirdre's biological family. Of her father Deirdre simply notes that he had 'a very unhappy childhood' in which he was frequently physically abused. On her mother's side, she was able to give a more detailed history of the transmission of maternal abuse. Both her parents physically abused all three of their children, but according to Deirdre, "I got the worst of it." There was no developmental history, and it was difficult to establish if constitutional factors played any sort of a role in Deirdre's perception that she had been particularly singled out for attack and punishment.

Violent enmeshment

Deirdre describes herself as coming from a working class Christian home in which 'we wanted for nothing materially' but were emotionally deprived and physically abused. In an atmosphere marked by poor boundaries, the entire family negotiated a violently antagonistic enmeshment. Extended family was frequently called in to mediate the violence enacted between the parents, or to rescue the wife and children from the father's assaults. Deirdre's father only stopped assaulting his wife when her younger brother was big enough 'to beat him up'. Any moves toward emotional connection or closeness between Deirdre and her siblings was instantly broken up or corrupted by their parents, causing intense rivalries amongst the siblings that apparently endures to the present.

Deirdre, after consecutive confrontations, had severed all of her primary family relationships over the decade since she had left home to become an 'independent' adult, although the way in which she policed the breaks ensured a continued enmeshment. She was anxious to present these ruptures in terms of her healthy determination to move away from toxic relationships, but on the other hand she was also characterised them as bitter betrayals. Without doubt they impacted on the presenting problem - these unintegrated ruptures had left her without an accessible family, to all intents and purposes isolated and bereft of primary support structures.

Personal history

Deirdre had little account of her early or formative years. However, she offered a narrative of her first night home after she was born, which described her father grabbing the infant Deirdre from his wife's arms when she returned from the hospital and giving her to her aunts to hold while he beat her mother up. Her mother told Deirdre this assault was made on the grounds that as Deirdre's blood type was different from his, she was clearly not his child, but Deirdre speculates that her mother was shamed in this way because she, Deirdre, was not male. This would seem to be borne out by the fact that her father again assaulted her mother the night that her sister was born, but not when their brother was born.

During high school years, Deirdre described an increasing recourse to withdrawal periods of sometimes up to 'two to three weeks '. During these periods her teachers would go easy on her, and she referred to these states in a matter-of-fact way as her 'ebbs '. Without collateral it was hard to confirm Deirdre's account of her childhood, but it was filled with accounts of mutual spousal

abuse, wife battering, and the unabated abuse of all three of the children. Nevertheless Deirdre stressed that her parents ensured that they were 'otherwise well provided for and well educated'. Not surprisingly, chronic anxiety persisted into Deirdre's adolescent life, and into her years as a university student.

Deirdre reported that her family professed to be devout Christians, but engaged with its precepts only nominally. However, she described herself as 'exceptionally religious', and many of her envious attacks on others were gilded over as inevitable consequences of her religious commitments, commitments that impelled her to choose her faith over more immediate secular gains. For example Deirdre reported that she had been deeply romantically involved with a man whom she'd left after he'd declined her plea to become a 'born again' fundamentalist Christian. When her younger sister married this man shortly afterwards, Deirdre severed her relationship with her sister and describes a period where she was clearly very unhappy and took some impulsive, life-threatening risks, such as crossing highways deliberately slowly in front of speeding trucks. There were other periods in her life where huge disappointments had overwhelmed her, but a chronology was almost impossible to establish in the history taking. Somewhere In her twenties, realising she was 'in trouble', she booked herself into a therapeutic treatment centre, where she underwent some group therapy.

Psychological treatment in early adulthood

This experience she describes as "having helped me deal with my anger, but it unfortunately left me without defences", and shortly after leaving the treatment centre, Deirdre resolved to become involved in the first relationship that came along with a view to getting married, citing that the 'born again' doctrine supports marriage as the true Christian way. Additionally, she selected a particularly auspicious part of the religious calendar to pray for a marriage partner, and when her husband-to-be entered her life shortly thereafter, she was convinced that it was a marriage that was 'meant' and blessed by everything sacred to her.

The difficulty in obtaining a 'history'

Deirdre's family, particularly her mother, were opposed to her relationship with her husband from its inception, an opposition Deirdre contemptuously describes as deriving from her parents' class bigotry, "I was educated, and financially independent, and they said, 'So now who's this piece of unemployed shit from Muizenberg?" Ongoing opposition by her family to the relationship led to

violent exchanges, including Deirdre being kept a prisoner in her sister's flat, and an apparent attempt by her father to push her off a six story balcony. Humiliating public finally led to Deirdre bringing a restraining interdict against her mother, and to a final severing of the relationship with her parents. It is not possible to verify the 'accuracy' of any of this narrative; indeed obtaining a history at all proved to be difficult as Deirdre jumped from one traumatic cluster of events to another, and there appeared to be no 'flow' to her life experiences.

Relationship and marriage

Despite knowing that her husband's previous romantic history was complicated, and that he was leaving his child and a wife five months pregnant with another, Deirdre pursued a relationship with him on the basis of its having been religiously ordained, and because of her propensity for excitement, "Yes, I knew...in fact the more shit I saw there was, the more sucked in I became". After the divorce she became Simon's second wife. She reports that although she did not then want a child, on his behest and insistence she agreed to have one. Seamus, now aged seven, was born in 1997. With financial backing and business acumen supplied by Deirdre, her husband set up a company doing plumbing and handiwork. According to her, their marriage was 'exceptionally happy' - the model of what a good Christian marriage should be their happiness marred only by the vindictive envy of his ex-wife and her mother.

One year into this second marriage, Simon, (under duress supposedly because he believed his 'promiscuous' and 'abusive' ex-wife was not parenting his children adequately) instituted an arrangement whereby he spent alternating one week stay-overs between this first family, and his second family, Deirdre and Seamus. This arrangement understandably became emotionally and religiously unendurable for Deirdre, and she finally forced Simon to choose between his first family, and her and Seamus - although she cited the detrimental effect his behaviour was having on Seamus as her sole motivation for making him choose. Prior to this, Simon had been expressing reluctance to choose or act either way, and Deirdre described this as a period of unendurable anxiety, rage and pain for her. She reports that during this period Seamus was exposed to seeing her 'in a terrible way.'

The end of the marriage

Deirdre demanded that Simon take legal steps to remove the children of the first marriage from his

ex-wife so that she could adopt them herself, and so that he would not therefore feel he had to spend alternate weeks at the first wife's home to 'protect' them from his ex-wife. Simon dragged his feet in taking this step and this became the basis of further conflict between them. Deirdre came back home one day to find that Simon had packed his things and left. She maintained that they had not heard from him since, and that she had brought Seamus to the clinic because she was concerned that Seamus "had not reached closure " with his father's departure. It appeared that Deirdre had also had to terminate therapy elsewhere because her medical aid had run out, and that while Seamus was indeed angry with his father's abandonment, it was Deirdre who was the more fragile, and who had not reached closure with his departure.

Anxiety and fear around lack of control

After two sessions, Deirdre admitted to having recently beaten Seamus with a sjambok, although it became clear in subsequent sessions that this had happened before. While she expressed anxiety and fear around her lack of control, and there was deep shame, she rationalised these events as isolated incidents in which Seamus had 'wound her up'. Seamus had clearly survived by becoming the parental child, highly vigilant of his mother's every mood and instruction. Seamus reported that the beatings he received from his mother were "my fault – I was naughty", even though on each occasion the events leading up to the abuse revealed only insignificant transgressions, or age-appropriate explorations of autonomy on his behalf.

Clinical Impression

At intake, dressed casually in a tracksuit and a red fluffy beanie, Deirdre initially came across as a calm and composed woman who did not have to try too hard to impress and she appeared to be comfortable with herself. She presented as an intelligent, progressive thinker, and her manner of engaging with me appeared forthright and open. Her help-seeking behaviour in bringing Seamus to the clinic, and apparent familiarity with 'psychologised' terms, seemed at intake, to indicate a capacity for insight and psychological-mindedness. Although there were clear references in the intake session to deeper waters, it was hard to marry Deirdre's outer physical and emotional 'togetherness' with the fragmented, deeply disturbing and turbulent history of physical and emotional abuse that began to unfold in Session Two. As subsequent sessions unfolded, the real depth of the underlying pathology began to emerge.

Intervention

Initially, while a full history and mental state examination was still being sought, I contracted to see Deirdre's son for a further six sessions. From early on, although we connected well, it was clear that the child would engage with me at a level of straight-forwardness sanctioned by Deirdre only, that he would not give away anything that his mother did not want given away, and that the best hope for intervention lay with Deirdre herself and not with the child himself. Short-term individual therapy of twenty sessions was offered to Deirdre.

Once Deirdre accepted short-term therapy, more limited goals were established. I attempted to forge a therapeutic alliance with Deirdre that would firstly concentrate on getting her to face the re-enactment of abuse in her own parenting, and secondly to work with her to identify the immediate triggers of the abuse and the brakes that could be implemented. Additionally, after Deirdre's basic lack of psycho-social understanding of childhood development, and her unrealistic parenting expectations had been identified, it was suggested that she take herself to learn ongoing parenting skills at The Parent Centre.

Deirdre diligently pursued sessions at the Parent Centre, and in her therapy with me we explored several painful themes that established her difficulties as emerging largely from the rapprochement sub-phase of Mahler's separation / abandonment developmental phase (Mahler et al, 1975). Her acknowledgements that most of her relationships had failed because of her inability to compromise, suggested that she might have sufficient insight to be supported to develop a more integrated, dependable, complex and positively valued sense of self. Her guilt and shame around her parenting, and her admission that some of her abusive enactments towards her son were triggered by her own feelings against the father as well as the unrealistic expectations she had of the son, suggested a capacity for insight. For these reasons, at the end of 2003, Deirdre was offered long-term therapy, which she accepted. In 2004 we began therapy using the outpatient's therapy rooms at Groote Schuur Hospital where I was an intern.

CHAPTER FIVE

CASE FORMULATION

Before I had gathered a clear picture of how brittle Deirdre was, I was asking ordinary post-intake questions that presupposed a far greater level of self-cohesion. However, once the extent of her use of primitive defences such as denial, projective identification and splitting had become more evident, I had come to a provisional diagnosis of a possible Bi-polar II diagnosis on Axis I and a Narcissistic / Borderline Personality Disorder on Axis II, The clinical grounds for reaching this diagnosis are outlined below.

Axis 1 - Bi-polar II

Pervasive underlying depression and anxiety emerged as Deirdre's mental state. She described battling with insomnia, with irritability that mounted swiftly to uncontrollable rages, as well as frequent episodes of obsessive brooding with accompanying tears. In the course of the sessions she also described overwhelming anxiety attacks; breathlessness, butterflies in the stomach, a sickening sensation of hollowness, and of experiencing 'exceptional emptiness'. Over and above the state of deep organic anxiety indicated above, she described a state of psychological confusion, agitation, and utter aloneness: Herman (1992) notes that this disregulated emotional state is a feeling that is almost impossible to put across, and Bion describes it evocatively as the experience of 'nameless dread', Deirdre described this feeling thus;

> That feeling? Well, I feel totally...weak. There's no sense of rationality...I'm exceptionally angry...I feel desperate, sick...I can smash anything or everything... There's a hole...here, right here... *points to her heart*], like someone could... just reach in and rip out my heart. [*Voice breaks*]

Deirdre made reference to previous bouts of insomnia when she was at university, where she wouldn't feel tired the next day, rather;

> I'd keep going all night you know, and in the morning I'd be exceptionally energised and happy, I'd be laughing and laughing like mad, and running around! I had so much of energy, my friends would think I was quite nuts!

She compared this euphoria she used to experience after a bout of insomnia to the exhaustion and intense depression she felt when she was depressed and couldn't sleep. I felt that her description of her 'exceptionally energised ' state suggested a Hypomanic Episode as described in the DSM IV, where it is noted that,

> Individuals may not view the Hypomanic Episodes as pathological, although others may be troubled by the individual's erratic behaviour. Often individuals, particularly when in the midst of a Major Depressive Episode, do not recall periods of hypomania without reminders from close friends or relatives. Information from other informants is often critical in establishing the diagnosis of Bipolar II Disorder. (2000, p. 393)

However, without this collateral from friends and family, I felt on balance that Deirdre could probably be identified as having a Bipolar II diagnosis.

Axis II - Narcissistic / Borderline Personality Disorder.

A clinical picture emerged characterised by rigid defences, including grandiosity, hypersensitivity, aloofness, impulsivity, intense and unstable relationships, difficulty with anger and perceived insult, that is, a clear picture of both narcissistic and borderline personality disorder features. I found it hard to give predominance to one over the other, and viewed Deirdre as being somewhere on that continuum, "with overlapping tendencies to overidealise, to devalue and to manipulate." (Adler in Brooke, 1992). Her rationalisations point to massive splitting between her idealised self and her abusive self. Overall, these defences led to a further diagnosis on Axis II of Narcissistic / Borderline Personality Disorder. Later on in the therapy I saw the way she continually scanned the horizon for the next attempt to "moer" her as indicative of her paranoid anxiety and her associated fear of contempt and humiliation. Her persecutory fears of being abused and despised I saw as the intrapsychic backdrop to her vindicated and triumphant inflation.

Developmental pathogenesis

In initial attempts to formulate, I concentrated on the psychogenesis of what I saw as her depleted narcissism emerging out of a borderline attachment pattern. At the root of all Deirdre's difficulties seemed to be defences against unbearable pain; a process of splitting that allowed her to lead her external life only at great internal cost. I found it useful to conceptualise the pathogenesis of these

difficulties within the broad overview of Benjamin's (1990) intersubjective interpretation of developmental achievements. Deirdre's specific experience of ongoing abuse, and denigration by early caregivers had obstructed her negotiation of critical developmental tasks, and distorted her ability to relate meaningfully to others. Deirdre's failure to negotiate the "crisis of recognition" within her early object relationships had impacted on her ability to enjoy a life in which she could feel simultaneously grounded, bounded, continuous and spacious, (Brooke 1992, p.5) and left her unable to respond empathically and creatively to others.

Pathologies "of" and "within" the self

Ongoing assessment of her various self-cohesion factors, enabled me to locate Deirdre, despite her initial presentation, more firmly in the pathological range of characterological disorders as the therapy progressed. Brooke's (1992) paper reviews the literature contributing to the conceptualisation of pathologies "of" the self and "within" the self - a distinction that refers to significant structural differences. Brooke summarises pathologies "of " the self, as involving a myriad of conflicting feelings;

> ...(feelings of) being split, fragmented and precariously unstable, with little room for feelings, conflict-holding or memory. One feels persecuted from within and without. There is a longing to be understood, yet a terror of being swallowed One feels engulfed by the other's understanding; there is a longing to feel autonomous and independent, yet terror of being abandoned. Separation and loss are an unbearable pain. On the other hand, for those whose difficulties lie "within" the self, there exists a relatively cohesive self inside of which greater complexities and conflicts can be held pain. (Brooke 1992, p.5)

Pathologies "of " and "within" the self are viewed as relative terms, and in between there are narcissistic personality disorders that lie on a continuum that runs through from neurotic to borderline pathology. The milder form of such narcissistic disorders would present with a neurotic self that is relatively cohesive. However, Lichtenberg refers to those severe forms of narcissistic disorder where the defences of grandiosity, contempt and independence, " are a thin veneer covering a self so tenuous that it is prone to borderline fragmentation" (cited in Brooke 1998).

Deirdre's stark 'splitting' and primitive defences placed her within this range of borderline pathology. As the name would suggest, 'splitting' is not a slowly unfolding, benign developmental process

whereby different parts of the mind become disconnected and simply drift apart, but involved considerable violence, "...since normally integrative tendencies in the psyche must be interrupted by force. Splitting is a violent affair - like the splitting of an atom." (Kalsched 1996, p.13)

The family history as reported by Deirdre suggested powerful undercurrents of envy, archaically projected as attacks against her, with a concomitant descent into decompensatory states when these primitive defences were overwhelmed. Her account of her experiences from abused child to 'independent' adult, was punctuated by serial and larger-than-life experiences of betrayal; "She lied, and lied, and lied", with implacable severances, "And when I cut you, you'd better know that you are dead and buried!", intensified "trust-in-self" statements (Brothers 1995) "I'm exceptionally principled, you see"; and by the starkly primitive splitting mentioned above, "I always knew that *I* was the gold, and that *she* was the shit." This range of defences has served to protect her from acknowledging underlying feelings of inadequacy, envy, loss and unbearable pain, but has ultimately left her in 'splendid isolation' (Kernberg 1976) without significant social support.

Shifting ego states

Beneath this grandiosity, Deirdre tried to steer her way through volatile and unstable states of mind that moved swiftly from hatred to anguish, an emotional lability that alternated with feelings of numbness; the core of this experience is that the self is not experienced as continuous. I was struck by in how short a space of time she could 'flip' from experiencing herself as either invulnerable/ aggressive, to experiencing herself as vulnerable/ persecuted. Within a minute she could move from expressing retributive hatred, "When I walk away, you are dead and buried', to expressing inconsolable pleas for her aggression (projected as others' persecution) to end, "[*Weeping*] Why do they all do this to me, in all my relationships? Why do they wind me up like this, *knowing* as they do that it will push me over the edge...*knowing* it's the last thing I want to do...?"

For Deirdre with her poor boundaries, the conflict, trauma and anxiety endemic to her life were all perceived as suffering caused by others. Insofar as others were always to blame for her distress, "...this outlook can be characterised as paranoid, and (her) anxieties as persecutory' (Klein in Brooke 1992). However, it was not until the second year of her therapy that the *predominantly* paranoid organisation of her personality became apparent to me.

"Exceptionally principled"

Deirdre's extreme defence structures leant heavily on an idealised self in which inflexibility and the inability to empathically integrate the viewpoint or emotions of others in her selfobject relationships was very clear. Yet these defences were sanitised and gilded with the self-description she frequently returned to - that of being "exceptionally principled". In the first year of her therapy with me, I came to identify the word "exceptionally" with her, as all her responses then were prefixed with it - Deirdre was only ever "exceptionally" angry, "exceptionally" upset, or "exceptionally" principled.

Deirdre's description of her family home as a place where one had to be, "black or white, there was no grey - you had to choose", indicated the source of this inflexibility. Psychoanalytically, linked to the healthy ability to experience one's conflicts as located within oneself, is the experience of being able to tolerate ambivalence. The experience of ambivalence is seen as presupposing a degree of internal resourcefulness and cohesion of the self, and in Deirdre its absence indicated the degree to which the developmental achievements of her childhood had been disrupted - she is incapable of giving an account of relationships in which she experienced ambivalence. She can not tolerate ambivalence, since such differentiated and more complex self-trust criteria would force her to "face or forgive the loss of (her) idealised loves and denigrated hates," (Brothers 1974) - the very defences that hold her together.

Injuries to early subjective reality

Cohen and Kinston (1974 in Brothers, 1974) conceptualise intrapsychic trauma, resulting from early emotional ruptures, as leading to defects, almost absences, in the psychic structure. Metaphorically this defect is frequently experienced as 'a hole' - the exact term Deirdre uses to describe how she feels when overcome with disintegration anxiety. Lamb and Auerhahn refer to trauma as, "an event that defies representation and instead is experienced as an absence." (1993 in Brothers, 1974)

The expansiveness and imagination that self-trust and cohesion confer, appear entirely lacking in Deirdre's emotional life. A sense of massive disappointment in the malignant mother who refuses to mirror back any of the omnipotent self, is reflected in Deirdre's few moments of depleted narcissism where all hope in relationship and the possibility that she can be received or understood by others is renounced. What appears to have taken the place of hope is a powerful desire for retribution, the hope of thwarting others as she has been thwarted.

It was not until the second year of therapy, that I became aware that the nature of her envious attacks had shifted from outright antagonism to stealthier forms of aggression involving disavowal, and unfortunately it was only at the end of the therapy that I became familiar with Bollas's term for this kind of repudiated aggression - the term 'violent innocence' (1992). Nevertheless, in the earlier days of the therapy, some emissary from the intersubjective field must have at least partially apprehended this paradoxical characteristic of Deirdre's, as I had attached a quote from Grotstein, "Where innocence has lost its entitlement, it becomes a diabolical spirit" (in Kalsched, 1995) to the front of an early essay I'd written up on her case management.

The preponderance of sadism

The overtly sadistic tone she used whenever Deirdre recounted conflictual encounters with others was usually accompanied by a narrative expressed as *their* betrayal, and involved grandiose accounts of how she had severed all contact, but had done so in such a way that the tables were now turned, and it was now 'they' who would be feeling the significant distress that she had previously been feeling. Her retribution lay largely in the disruptions she caused, and in the frustration of others' selfobject relationships. In Ornstein's (1992) useful differentiation between masochism and sadism, one can detect in Deirdre's make-up how the preponderance of sadism over masochism reflects, "an early massive disappointment by, or absence of idealised selfobjects, and a resultant reliance on the primitive grandiose self." Ornstein suggests that masochism is preponderant when the child has experienced a neglectful or indifferent environment, whereas sadism is preponderant when the child experiences the emotional environment as unpredictable, volatile and violent. Deirdre's sadism is prominent, and is underwritten by what Kernberg has characterised as a 'malignant grandiosity' (in McWilliams, 1994, p.153).

Whenever Deirdre was encouraged to consider motivations other than aggression directed towards her, and to consider different responses herself to such possible motivations, she was unable to tolerate the inner conflict it engendered, "The capacity for concern is borne of the recognition that one's aggression is really one's own, that it is not merely an innocent's response to a frustrating world, and that it has an impact upon those whom one loves and needs. To be concerned is to own both love and aggression, and to tolerate this conflict in one's felt interior." (Brooke, 1992, p.10). In the second year of therapy, Deirdre's attempt to disavow her aggression and to establish her 'innocence' was made possible through the establishment of a falsely 'innocent' self who denied her

impact on others.

Where her acts of violent innocence retained an unconscious organising dynamic, they were unpleasant to experience, but tolerable within my understanding of her archaic defences. Increasingly however, the more her violent innocence 'succeeded' and met her seemingly insatiable need for omnipotent control, the more the unconscious aspect to these enactments eroded. At a certain points in the therapy, particularly towards termination, it felt as though there was nothing unconscious about her use of power; it was literally 'shameless', and I deal with this in Chapter Six. Whereas her previously disorganised outbursts as an outright paranoid had sometimes also been accompanied by guilt, or the defensive need to explain herself, it seemed as though Deirdre had moved into the outright display of "getting over on", or to the conscious manipulating of others that characterises the psychopath (Bursten in McWiliams, p.152). McWilliams notes that, "The primary defensive operation in psychopathic people is omnipotent control. They also use projective identification, many subtle dissociative processes, and acting out." (1994, p.152)

Interestingly, clinical lore (McWilliams, 1994, p.157) suggests that children who become sociopathic have often been materially indulged, and emotionally deprived – almost exactly Deirdre's description of her family background in her intake history. Most psychoanalytic writers emphasise the failures of internalisation in the development of sociopathy, whether these arise from temperament or from environment, "The antisocial person simply never (to any normal degree) attached psychologically, incorporated good objects, or identified with caregivers." (Grotstein in McWilliams, 1994, p.156) I mention these in passing because towards the end of the therapy I did feel that Deirdre's desire for omnipotent control had become rampant – to the degree of psychopathy. However, I have taken a cue from Giovacchini who notes, "When one wishes to study the therapeutic interaction – the main interest of the clinician – such diagnostic distinctions are of limited value" (1972, p.231), and I have therefore not explored this further in this thesis.

CHAPTER SIX

THE ILLUSTRATIVE MATERIAL AND DISCUSSION

From the start of the second phase of the therapy during the internship, I struggled to regain and to retain a sense of the integrity of the therapy. This sense of integrity - without which the therapy felt at best thwarted and, at worst, unethical - was largely to elude me throughout most of the therapy. In my patient, it played itself out in the emergence of a pathologically 'violent innocent' false self, and in myself it played itself out in progressively false adaptations to her false self, as therapeutic endeavour after endeavour was 'outwitted', inducing an increasingly deadening sense of uselessness in the therapy.

I am using illustrative material from the second year onwards, but analysing the therapeutic impasse from the viewpoint of the last two months immediately prior to termination. I provide a brief history of the therapeutic techniques up until this point, as they establish a history of the therapy that is germane to the therapeutic impasse.

The Emotional Storm

Deirdre's use of the therapeutic space was typically marked by a quiet in which she would select an incident from the week, and rapidly escalate her account of it into an emotional storm marked by enraged affect. These sort of 'narrative escalations' from single infractions into 'the widening gyre' (Bollas, 1992, p.130) of disturbance indicate how,

> ...the borderline object functions as an emotionally impacting stimulus, that upon evocation arouses the sensorium. The fact that the borderline object is most often on the border of the external and the internal – linked to an external happening, yet immediately evocative internally – testifies to the unconscious place of the borderline's primary object: an outside that is simultaneously an inside. (Bollas, 1990, p.130)

I experienced this as a heated, pressured 'wall-to-wall talking at' me that had to be interrupted with some effort, and early on I learned that I would have to *insist* on finding out where *she* was in all the hair-splitting furious detail, an interruption that often deeply offended Deirdre. I would ask her to stop, and simply identify how she *felt* underneath all the detail she was giving me. Frequently she could not find the words, so I would ask her to give me a somatic description instead, which she

found somewhat easier. If I persisted in keeping her in contact with this feeling, she would sometimes identify a feeling and quite suddenly collapse into wordless grief.

Quiescence as the absence of the object

At the moment she contacted her affective state, the emotional turbulence would subside, and Deirdre would visibly empty herself of inflated rage. She would appear crushed and lifeless as she fell silently into what felt like complete abandonment. There was a concomitant sense of desertion while she struggled to find herself. At the moment where one might expect some space for the processing of pain, Deirdre would instead appear to reject the space made quiet enough for it, and seemingly search for the turmoil that had led to the grief in the first place. In this sense, Bollas's contention that "turmoil is the presence of the object, and quiescence is abandonment", (Bollas 1999, p.130) was borne out by the way in which Deirdre traversed the border between fullness and emptiness that constituted her early dyadic object.

While in this grief, Deirdre would silently receive interpretations without comment. However, engagement with the interpretations did not happen; rather Deirdre would weep, and beg me for relief from her painful feelings. She would supplicate for ways in which she could escape this wheel of cruel repetition; a treadmill in which she experienced herself as mercilessly provoked, where her bewildered anguish would move into an unwilling rage, a state of unendurable emotional turmoil where despite her struggle to maintain control, she would be enticed, trapped and cornered into self-defensive outbreaks of anger and violence. Once goaded into this defensive aggression, she was undone, experiencing herself as abandoned in pious disgust by her tormentors who could then, to all intents and purposes, then appear to both others and to themselves innocent of any aggression.

That Deirdre experienced this disavowal of aggression as annihilatingly painful was evident. That she also experienced it as violating was clearly what gave her repetition compulsion its paranoid presentation. While I understood that the psychogenesis of a borderline pathology of the self meant that it would take years to effect real change, I had envisaged a useful process of therapy in which Deirdre could at the very least, be supported to access a nascent observing self. I felt supported in this hope by Deirdre's faithful attendance of therapy sessions, by her diligent follow-up of suggestions around her parenting of her son, and by her own apparent willingness to engage with cognitive reframing where it was couched in non-judgemental and empathic terms that her narcissism and paranoia could tolerate.

Having experienced the way in which Deirdre used the therapeutic space, her pattern of being 'stirred up and then abandoned', and realising that a year would not be long enough for the necessary transference to be effected, my intention was to support Deirdre's use of boundaries and to encourage more adaptive strategies to deal with emotionally impacting stimuli. However, as Bollas points out, the therapist's 'good enough' technique is frequently experienced as "depriving", and "well-intentioned therapeutic endeavours" often support the borderline's false self (Bollas, 1999, p.131). I discuss a number of these below.

Witnessing and mirroring

Initially, while getting the measure of Deirdre's inner world, I allowed her to use the sessions to let off steam, reflecting back to her that she experienced her life as being radically unsupported. Very early on, it became clear that witnessing Deirdre's disorganised outbursts, and allowing her to vent without pause for an entire session was not therapeutic, and, in an attempt to introduce some reflective space, I hazarded some interpretations of her defences.

Interpreting defences

Interpreting defences were not well received; genetic interpretations were batted off as banal (I myself began to view these as the 'duh!' interpretations), and interpretations that dealt with primary defences of the self such as projection and denial, were superciliously dismissed as, at best, my naivety, and at worst, my naivety in league with her enemies. In line with borderline defences, any interpretation of her defences seemed to render me potentially annihilating or abandoning, or made me feel as though I was robbing her of a precarious autonomy. This paranoid personality organisation meant that there was usually intense pressure on me to simply confirm projections of her difficulties as being external in origin, and I became anxious to engage in a different containment process that actively avoided this.

Interpretation of life-stresses and feelings

Not wishing to validate her prominent grandiosity and paranoid ego weaknesses, but disbarred from interpretations, I began rather to identify some of her everyday stresses and to link these to her underlying feelings ("I notice that the way you experienced today's staff meeting made you more upset than usual, and I'm wondering if this is because you're feeling anxious about the upcoming

peer review?"). At times uncovering the separation / abandonment anxiety that triggered the intensity of feeling allowed for more reflective space to open up, but more commonly it was swiftly obliterated by freshly escalating suffusions of rage and pain.

Contrasting feeling states

This led to sessions where, if I could interrupt the pressured flow of Deirdre's vindictive outrage, I could prompt her to at least observe contrasting feeling states; "It seems to me that although you were very happy for Seamus to have this connection with your mother, at the same time you yourself were feeling exceptionally lonely and excluded." Sometimes Deirdre would glare irritatedly at these interruptions, and simply forge ahead with her re-enactment of the battlefront, but occasionally she surprised me by deflating swiftly into tears.

The collapse of defences

Deirdre presented with an extremely brittle carapace of defences dominated by a paranoid fear of being slighted, dismissed or attacked. Under this carapace of primitive defences, her affective state ranged from a depleted fear and shame to a corrosive envy and resentment - but it seemed as though envy predominated in the second year of therapy. Her envy of others' seeming advances alternated with a triumphant narcissism where she perceived herself to be ahead in the game. If, as she reported (and I had no reason to doubt), she had been repeatedly overpowered and humiliated in childhood by her parents, it was unsurprising that these internalised bad objects kept overwhelming her interactions with others, or that in the face of such powerful underlying affects, only her entirely ego-syntonic use of projection and denial could successfully ensure that no sense of shame or envy remained accessible to her. If ever her defences were breached – and occasionally in our sessions this happened – and she was confronted with a diminished sense of self, she could suddenly visibly deflate, collapse, and sink down into her grief. The annihilating force of this grief was palpable in the room. It was wordless, catastrophic – and frustratingly short-lived.

The uselessness of interpretations

I had learnt that interpreting to Deirdre while she was in one of her collapsed and defenceless 'drowning' states was the quickest way to short-circuit the therapeutic process, as she swiftly felt engulfed and needed to push away. If I interpreted her grief and tried to link it to separation, "Where

are you now Deirdre? Looking at you, it feels like you are someone very small and insignificant and alone?", this seemed also to function as a stimulus for her anger, as though drawing attention to her vulnerability was merely a precursor to my becoming triumphant. Using any of these therapeutic techniques, the possibility for Deirdre to engage with her emptiness was frustratingly aborted, leaving me feeling useless.

The aim of providing for a constructive therapeutic experience

In therapeutic terms, where I moved to next, was where I stayed almost until termination with Deirdre. With hindsight I can see its limitations, and that will form part of this dissertation's subject matter. If the goals of therapy can loosely be held to be to reinstate an aborted developmental process, to re-establish an intact sense of self, and to provide an enduring selfobject relationship, then with Deirdre I hoped only for what I saw as the limited goal of providing her with an experience of a consistent, non-overwhelming and non-hurtful relationship, and to build a constructive therapeutic experience. Within this experience, I hoped she might learn to internalise some of her projected contents, to begin to conceive of a more complex, multi-dimensional self, and even come at the end of the year to a point where she could tolerate the bare outlines of an interpretative formulation.

Background to the therapy sessions

Deirdre's gradual metamorphosis into the violent innocent was not entirely without precedent in our therapy sessions. I had been the recipient of this kind of violent innocence the previous year when I had terminated therapy sessions with her five year old son, and when Deirdre's acting out around this termination left me feeling deeply provoked and disturbed – as well as utterly incapacitated by her 'innocence'.

To illustrate, I include here a revised excerpt from case notes written up in the first year of therapy with Deirdre. The incident took place after I had seen Seamus for six of eight sessions. I had been wrestling with anxieties about when and how best to engage with Deirdre when I received another attack from her - an attack that left me flailing in disbelief and disorientation. She had warned me that she felt Seamus was deeply invested in the therapy with me and was not ready for termination yet. I in turn had explained once again that I could not continue to see both her and Seamus. I assured her that I had worked through the termination with Seamus very

carefully for several sessions now leading up to the impending termination. Realising eventually that I was not going to change the contract, she cornered me at the end of one of Seamus's penultimate therapy sessions, and told me that she had devised a brilliant solution to the problem of getting Seamus to accept that he could not continue to come and play with me,

> I told him "Look - Max can only have one friend, Seamus; she can choose only one us. Let's play a game to see which one of us she chooses. Let's play Eeny-Meeny-Miney-Mo...".

By choosing the '*Eeny-Meeny-Miney-Mo, O-U-T spells...OUT*!' ditty to eliminate Seamus, and to drive home to him the cruel randomness of my 'choice' of 'friend', Deirdre managed to kill two birds with one stone; she triumphed over Seamus, and she punished me by irreparably damaging the relationship of trust that I had established with him in the therapy sessions of the prior six weeks.

The physical impact of this attack alone was astonishing to me. For the rest of that day and the weekend, I doubled-up as though I had been punched in the belly and groaned every time I thought of Seamus's face when being told of my 'choice'. Then I felt flashes of fury that burned away all thought, but failed to have any cathartic effect. Inside, I felt strangely and bewildered and 'undone'. Mostly, I felt utterly powerless.

In the end I came to understand that Deirdre had in fact given me the closest taste of her own painful experience of being 'set-up', overpowered, and of 'no win' that I could get. I couldn't help acknowledging the justice of being hot-wired to her experience of loss, abandonment, and rage. In her eyes, I had abandoned Seamus, having led him to believe that I would protect him. As Valerie Sineson (Personal Communication, August 2002) explained, in Deirdre's eyes Seamus was now unprotected from an abusive parent (herself), and worse still, it was not as though I was completely unaware that he might be being abused, because Deirdre herself had told me that she had beaten him before. Deirdre had exposed me to myself as a corrupt and incompetent voyeur. I was beginning to feel the 'sting' of Deirdre's retribution, and to understand that even in short-term therapy with limited goals, I would undoubtedly experience it again.

In bringing Seamus to the clinic as the Identified Patient, but unconsciously ensuring that *she* would receive the therapy by telling me about having beaten him, Deirdre had me 'set up' from

the beginning to enact a therapeutic betrayal. And even if I had continued to see Seamus, Deirdre's inability to see him as separate and her envy of my autonomous relationship with him, (which had already surfaced in the form of other attacks on both of us) would have meant that a 'split' situation would inevitably have developed.

I felt as though any possibility of achieving 'good' closure with Seamus had been sabotaged, and indeed I couldn't get Seamus to hold any meaningful eye contact with me after Dierdre's intervention, although his compliant self trudged dutifully through the motions of termination.

The issue of being chosen: loss, envy and triumph

It was significant that Deirdre had selected the issue of 'choosing', as the entire issue of choosing was cathected for her - more particularly the issue of *not* being chosen. I thought about what it must be to have had a father who rejected you at birth because you were disappointingly not a boy - and so chose not to celebrate your birth, but to beat up your mother instead; of your sister being chosen rather than you by the man you love, of the bitterness of the ex-wife being chosen over you, of the children of the first marriage being chosen rather than your child. So while Deirdre was indeed very angry with me when I insisted on termination with Seamus because she herself could not bear the loss and abandonment, there is also triumph in the fact that I 'chose' her over Seamus. I was left with some consolation that there was protection in this for Seamus, in that he could no longer be envied.

In the second year of therapy, after I refused to see her when she arrived for therapy with a sick and feverish Seamus in tow, Deirdre punished me by refusing to include any substantial material about Seamus in her therapy sessions with me. She was dismissive if I asked her to elaborate passing references to Seamus, "Oh no, I've discussed all that already with Belinda at the Parent Centre..." she would say breezily. Deirdre made it clear that I had abdicated the privilege of hearing about Seamus and now piously insisted that the boundaries I had put in place be kept.

However, one day I got a phone call from her, who said quickly, "Just hold on Max, there's someone to speak to you..." and the next moment Seamus's voice came through, and in a small rehearsed voice, he said, "Hello Max, it's my birthday on the 22nd of September – please will you come to it?"

Deirdre knew that I would refuse to come, as we had discussed the implication of termination

with Seamus not once, but several times. Yet once again I was so astonished at the apparently conscious way in which she was prepared to use Seamus to 'set me up', that I was momentarily speechless. I recovered enough only to make a warm apology to Seamus without furnishing reasons for why I couldn't come. I asked him what he was looking forward to about his party in order to detour the conversation elsewhere and to 'soften the blow' of refusal - if indeed it was a blow. I suspected that the last thing on Seamus's mind was asking me to his birthday a full year after we had terminated our therapy together, and that Deirdre had put him up to it in order to unsettle me; a little 'blast from the past', so to speak.

Feeling the powerful effect of the primary object

It is evident that the particular form that this aggression takes reveals the powerful effect of a primary object on her ego, and that on both occasions I was being hot-wired to a disturbing experience of being thwarted that she understood in some deeply familiar way - although I had not been able to precisely identify this experience, the experience as Bollas so elegantly puts it, of "being with an other who provokes and then departs, innocent of the act of aggression" (Bollas 1992, p.191). In spite of - or more precisely, because of - these violently innocent 'stings' that Deirdre sets up, I have been astounded at the vigour and effectiveness of her 'primitive' defences, and in calmer moments, I have admired the way in which the abused child in *her* has rallied to protect some inviolable spirit within herself.

Re-establishing the frame after the break

Whereas the previous year's sessions had dealt primarily with Deirdre's relationship with her son, and with supporting Deirdre to come to terms with her ex-husband's abandonment of her and her son, the new year's sessions took on a particularly paranoid flavour. As discussed above, the first frame break occurred when she brought her sick son to our second session, and she was mutinous and hurt when I refused to hold the session with him there. Secondly, in the hospital setting where I was now an intern, she took umbrage at all the inevitable changes this change occasioned. Everything became a trigger for outrage; the new venue, the raised fee structure, the bureaucratic hospital administration, the inept filing system, the indifferent staff, the constrained times etc. She arrived late for sessions, and when I insisted on ending on time, she began calling me on my telephone late at nights from public phone booths with her small son in tow, citing such urgent distress that she'd needed to drag her son down to the main road in Muizenberg to call me.

The necessity to re-contract with the patient

These enactments were such that I eventually needed to put aside a session purely for the purposes of re-contracting with her. She was surprised at this intervention, disavowed experiencing difficulties with the adjustments, agreed to all the new terms, denied feeling angry with me - and queried whether the account for this contractual session would be hers to pay, since I was the one raising problems with the contract? In the time remaining in the session, she detoured her unexpressed anger into an explosively contemptuous rage about the government health system.

The paranoid outlook: A wolf in sheep's clothing

Recontracting evoked a "widening gyre" of contemptuous rage (Bollas 1999, p.128). She scarcely drew breath - public health was actually to all intents and purposes "already privatised, a wolf in sheep's clothing, much like all the other promises made to the working class by perfidious elites who were nothing other than the lackeys of international capital. The hospital belonged to the people, but it was in fact a wolf in sheep's clothing", and so on. Hence arose the first intimations of the predominantly paranoid personality organisation that Deirdre was to display throughout the rest of the year's sessions - she raged about how things were not as they seemed, that there were other agendas, and the players typically concealed their true motives.

Deirdre's disposition to oppose

The experience of being repeatedly overpowered and humiliated by both of her parents, has not surprisingly, created in Deirdre a disposition "eager to oppose" (McWilliams, 1994, p.64). She adopts ultra left wing, fundamentalist Christian and radical gender positions. These apparent contradictions sit easily with her because they are not well-thought out and integrated positions; they most often function as shallowly adopted beliefs that allow her to discharge considerable aggression in defence of the oppressed, as her own sensitivity to humiliation hones in on the underdog of the moment. What her beliefs lack in consistency, they make up for in intensity – or rather this was how I felt when I was overwhelmed by her 'radically' inflated grandiosity, and when she presented herself as the agitprop poster girl. Nevertheless, behind the prominently oppositional presentation of her beliefs, there is undoubtedly a sensitivity to and primary identification with the suffering endured by the overwhelmed and marginalised of society that have their origin in her own real sufferings.

Isolation from kith and kin

Deirdre works for a small Christian business that provides research data to interested individuals who are supportive of social justice. The offices are located in a largely working class suburb of False Bay, and she also lives in a flat in this area. In the previous year Deirdre had cut the last remaining ties to any kin that remained connected to her – she was entirely without family connections. She explained to me that her work in support of the oppressed took the place of family for her. Without kin, I imagined therefore that Deirdre was located both occupationally and socially to make the most of kith, both in her community and her work environment. However, in the course of the next nine months, the extent to which her *every* relationship in both her work and home environment was equally fraught with allegations and counter-allegations of attack and violation became alarmingly clear. This dissertation looks at enactments in the work situation only.

'Grievance' as an organising principle.

There is something intrinsically unresolved implied in the word "grievance". Bollas refers to the "clinging grievousness" of the borderline, a phrase that correctly situates the dynamic in problems of attachment. I am also interested in the fact that as Deirdre began refusing to 'misrecognise' in the interests of greater communication and interaction, she concomitantly became a stickler for everything that would paralyse greater connectness: a stickler for precision, for exactitude, and for 'procedure". She brought several separate grievance procedures internally against various colleagues in the small business, including its CEO and her immediate superior, but she also had a grievance procedure brought against her, received several warnings, one final warning, was compelled to make an apology, was threatened with a restraining order and had yet other charges brought and subsequently dropped against her. Therapy sessions resounded with outrage about attempts to '*moer*' her and her counter threats to '*moer*' others. Commonplace rebuttals, body posture, eye contact, comments, the smallest slight, all these excited litigious fervour in Deirdre, let alone an obviously curled lip or any suggestion of a smirk - all of these became grounds for evidence of an attack in the offing.

Within a small business, to arraign several grievance procedures in a year, is to present a paranoid and litigiously organising style of personal interaction. Deirdre was to spend the entire year bringing grievance procedures to bear; eagerly awaiting their outcome, and fulminating at thwarted justice if,

and when, they did not support her.

Flooding of the mind

Floundering myself under the weight of all these accusations and counter-accusations, unable to open up any reflective space, and being compelled to experience the heat of the battle through Deirdre's "flooding of the mind with excessive and overwhelming mental content" (Bollas 1999, 128). I was supported in my own supervision to forcibly interrupt her venting, and to insist that she try to contact what she was feeling underneath the attack. When I managed this, Deirdre sometimes obliged by dropping into abject states of shame, and would beg me to help her find a way to put some space between the provocation and her anger.

Creating space between the anger and the reaction : creating 'The Liberated Zone'

Over some several sessions we came to negotiate a space that Deirdre called 'The Liberated Zone'. 'The Liberated Zone' (as we both came to call it), was intended as a breathing space where Deirdre could suspend her black and white responses in order to explore alternative, more nuanced responses, and where I hoped she could begin to move away from her over-valued 'principled' self, and begin to see herself, and others too, as more multi-dimensional. Because borderline patients find it impossible to conceive of a complex, multi-dimensional self, this was hard work – Deirdre could only conceive of others as changeable in the untrustworthy sense, and by projecting her own sense of shifting identity onto others, she was able to avoid recognising that it was she who was not constant.

Russell asserts that our patients healing wishes are always trying to push through the pathology, and paradoxically even *are* the pathology itself (Russell 1998). Deirdre's pathology was her projected paranoia, and the healing wish buried in this pathology was to understand why she was 'attacked' in seemingly secret and unannounced ways. Deirdre frequently begged me to explain, "How do I always do this! How do I always attract this shit?" I did not doubt her persecutory anguish, but attempts to get her to explore this destructive hate herself, led only to ego-syntonic denials and projections.

Putting boundaries in place and using appropriate strategies

One day, cognitively trying to reframe one of her all out aggressive outbursts as a dysfunctional

'overkill', I used the expression, "You won the battle, but lost the war". Carefully, I suggested that using all her firepower for individual battles that in fact required far less psychic ammunition, left her without resources for completing the real business at hand, and cost her the war. Later, I was to regret using this metaphor as Deirdre clearly liked its bellicose feel: it supported her grandiosity and left the basis for her persecutory fantasies unchallenged. At the time I suppose I felt that this was admissible in exchange for exploring more adaptive strategies of being in the world. I needed a way to suggest to her that some battles, such as the one she had just brought up in therapy, were better ignored and walked away from, in order to win the peaceful environment she desired. Deirdre had warmed to this idea, "I mean, why use all your tanks if just one sniper can do the same job?" was her eager contribution.

The need to recognise a range of possible motivations in others

I confessed to her that I was being overwhelmed by the descriptive contents of her conflicts, and to wanting to work more with her underlying feelings. I asked her if we could ignore the "then he said... then I said..." detail of these battles, and explore a range of different motivations that colleagues might hypothetically have other than wanting to generally attack, thwart or humiliate her? Deirdre reluctantly conceded to do this, but constantly shifted the argument to why people could not be 'honest' about their motivations, why they could not, like her, just put them squarely on the table? I explained the communicative function of adaptive 'short-cuts' to her, that people, that *we*, *we* tend not to put everything squarely on the table because its altogether too much detail, because *we* need short-cuts to communicate, because it oils and lubricates the social process.

Misrecognition and misperception as creative communication tools

Bollas contends that human discourse requires an unconscious misrecognition in which we co-create each other in complex intersubjective play. This is an allowing, creative space, essentially embracing of each other's presence, where the demands for exact understanding are suspended 'in the interests of deep play'. Creative non-comprehension and misperception are the two pillars that support "the essential illusion" underlying human discourse, and Bollas conjectures that a 'violent innocent' may have suffered a rupture in that 'essential' early play with the other, a rupture in that essential creative misperception was disallowed. Maternal refusal to playfully misrecognise (a refusal that is experienced by the child as maternal death wishes against it) is introjected as the hateful enforcement of perceptive understanding, as is the "premature realisation that we are not

capable of understanding the nature of the other's inner self experience." - and this in turn paralyses our hope that we can be understood by the other (Bollas 1992, p.190).

Maternal violations of infant omnipotence

Although Bollas turns Winnicott on his head here, this is nevertheless a nuanced appreciation of Winnicott's formulation of the process of maternal recognition and the mirroring role that the mother provides in the child's earliest environment. If the mother does not "see" the infant, then the infant experiences himself as not existing, "Her responsive recognition – not for example, a conflict of recognitions between them – makes up his sense of himself. The mother is the constitutive witness of the True Self. If she violates the infant's initial omnipotence – forcing him to *see her* – she insults the infant's self and drives it into hiding" (my italics, Phillips, 1988. P.130). What Bollas has emphasised is the paradoxical and crucial role that playful misrecognition plays in the dance of recognition, and the aggressive, violating impact on the infant of enforcing understandings he cannot endure.

The protective value of grandiosity as a transitional phenomena

I hadn't then read Bollas's paper on the violent innocent, nor his paper on the borderline object of desire, in which he warns that therapies using adaptive strategies may support the creation of a false self in the borderline. Up until this point in the therapy, I could see how Deirdre's grandiose behaviour lay at the core of her difficulties with others, but my attempts to confront or interpret this grandiosity had been seen as 'challenging the paradox' of her infant self, and as attempts to destroy the subjective meaning and protective value of her grandiosity. Her grandiosity (with its expressions of envious attack) functioned as a form of transitional phenomena to protect her from feelings of fragmentation. Thereafter in the therapy, I continued to respond to what I saw as the healing wish behind Deirdre's pathology not through interpretations or challenges but by suggesting to her the value of editing out her suspicions, the value of taking less conflictual short-cuts to reaching agreements – i.e. the putting place of boundaries and adaptive behaviours. However, since "borderline patients conceptualise any change in their self-image even in a positive direction, as a theft on the therapist's part which leaves an empty space where they formerly existed" (Macaskill, 1982, 55, 349-360, p.353), I believe that Deirdre's move to perpetrate acts of violent innocence were unconscious attempts to fill this empty space with a compliant but false self, and that her enactments functioned as transitional phenomena in response to the theft that she unconsciously

felt I had subjected her to.

Have a nice day; enjoy the rest of your life!

To continue with Deirdre's response, she professed incredulity at these 'short-cuts' that I attempted to suggest to her;

> "So people in fact lie, and everyone knows *they're* lying, and *they're* all OK with this?"

I noted the disowned '*they*' pronoun, and went over the nuances again with her,

> "No, *we* don't lie, but *we* overlook stuff that gets in the way of smooth communication..."

> "OK, so *they* pretend then? They pretend to agree?"

> "No, *we* do usually say more or less where we're coming from, but mostly *we* don't take hard and fast positions because that forces others to do the same, and then it becomes the kind of stand-off that you so often find yourself in. *We* all have feelings about everything, but *we* leave some things unsaid, because it makes life that much easier."

> "So then *they* pretend not to care?"

> "... In a way, yes, I suppose *we* do..."

Deirdre shook her head in disbelief, and said drily,

> "Well! Have a nice day!"

Thereafter the phrase became Deirdre's 'by-word'. Sometimes she added,

> "Enjoy the rest of your life!"

I hadn't yet come across the concept of creative misperception, and did not then have the conceptual tools to reframe as 'playful' or 'creative' Deirdre's jaundiced view of this process as dishonest. With hindsight, I believe exploration of this concept could possibly have identified more clearly Deirdre's splitting into an adaptive false self, and - given her predominantly paranoid presentation - its expression as a violent innocent. If we had explored her experience of anger and

affect as 'pleasurable', as even 'blissful' as Bollas suggests, precisely because it summoned the presence of her early object impinging in provocative and challenging ways, we might have begun to understand why she refused to misrecognise – or to "edit out" - as I had put it in terms that she would understand.

So Deirdre's contemptuous "Have a nice day!" became her parting shot in all these innocently violent or violently innocent exchanges. When I was caught up in the negative countertransference, I saw it also as a calling card, a sly dig to let us all know that she was 'in on the action' too, that she knew that we knew, that she knew we were all playing at being what we were *not*. I felt stymied at Deirdre's provocative genius in identifying this unerringly accurate 'reaction formation'.

To return to the therapy; initially Deirdre was 'disgusted' by the notion that motives might be complex or multi-dimensional. It 'sickened' her that people were 'dishonest' enough to wear "all these different hats, whereas *I*, Deirdre, only ever wear one hat; *I* am always Deirdre!" When we explored her ruptured relationships in the light of her attributional negativity, she insisted that her 'principles' would not allow her to 'compromise her integrity'. As her paranoia made her quick to perceive me as potentially humiliating and in league with her detractors, I was unable to interpret her 'principles' as the defences they were, so I continued exploring adaptive strategies with her that might enable her to put brakes on her alienating and self-sabotaging encounters in the workplace.

The calm before the storm

It has to be said that Deirdre engaged wholeheartedly with this therapeutic strategy at the time, and with the same diligence that had previously impressed me in her attempt to become a better parent; she strove not to be reactive, and with the same vigilance she'd previously reserved for retaliation, she appeared to be carefully avoiding situations that might stir her up. We appeared to have made a breakthrough of sorts - the deluge of openly antagonistic and retaliatory attacks against colleagues dried up. Suddenly Deirdre could not be provoked into screaming matches at work. She appeared to let certain matters rest. Her colleagues were initially openly suspicious, then confused and finally relieved, as was I. This was however, the calm before the storm, a brief interregnum between the old furious Deirdre and the emergence of the newly calm, 'overly contractual', violently innocent Deirdre.

Fine print mentality

Over several months Deirdre's attempt not to be over-reactive metamorphosed into an alarming ability to appear to be without any affect at all. Without affect, she became liberated from attendant shame or guilt, and a cold, profoundly anti-social ego state emerged. Disowning her own hidden agendas, but discouraged from identifying them immediately in others, Deirdre's response was to persist in finding out exactly what her colleagues motivations were - to the point of persecution.

Deirdre elicited others' viewpoints with the precision of a surgeon. She revelled in this new skill, and in relaying her skill back to me. She had swiftly perfected a way of extracting people's motivations from them in a way that subtly rendered them into motives – a process that provoked growing paranoia in the person being questioned. Multi-layered, complex motivations were extracted and laid out in disconnected bits on the operating table.

Many of these 'unthought knowns' were then easily exposed by Deirdre as contradictory, self interested and - because they were previously unspoken – secretive. Why bother to be secretive, if your motives were not suspect? Flailing and increasingly divided, unable to match her hair-splitting fixation for exactitude, her colleagues became progressively bewildered, accusatory - and within a short space of time, very suspicious. Deirdre herself remained calm,

> "Look, I'm just trying to establish where you're coming from here, but...if *that's* how you want to see it - have a nice day!"

Whereas previously she had been given warnings for continually flouting loopholes in procedures, she now became a stickler for pinning colleagues down to rigid and exact definitions, insisting piously that she wished to understand exactly what they meant in order to be able to follow these procedures to the letter. She politely insisted that the minute taker at meetings read out the minutes at the end of the meeting so that minutes could be accepted there and then before any 'misrepresentation' of them could take hold. She then set ingenious entrapments for colleagues using these same procedures, quietly quelling the resultant outcry by citing the authority of the minutes. She derailed meetings with calm but obdurate semantic quibbles, supposedly for 'clarity'.

The compliant 'shift' into 'innocence'.

The calmer she became, the more subtly provoked to feel her paranoia her colleagues became. In the room, Deirdre was triumphant; never before had she felt so calm and in control! Never before had her colleagues felt so uptight and anxious! She revelled in this "shift" she'd made, in being able not only to access 'The Liberated Zone' that she used to battle with, but to have done so in such a way that she was able to mine the rich seam of others' paranoia in the process. When I pointed out that a true shift would enable her to connect with colleagues rather than isolate herself from them, she raged at the fundamental nastiness of her colleagues, and her need to get out of the toxic environment she found herself in.

From her reports, her colleagues were clearly at a loss, intensely disturbed and frustrated by these relentless 'innocent' attacks, and alone with me, she made no effort to disguise the retaliatory satisfaction in her voice, although if she were challenged in the slightest way about it, she would play innocent. If others felt bad because she was calmly seeking clarity, what could she do about it? In one session she pointed to herself, and crowed, "All that shit that was in *me*?" (Leaning forwards excitedly in her chair, and stabbing her finger at me, "Well now it's in *them*! It's *their* shit now!" Wilting under the burden of this democratically dispersed projective identification, caught up in my own countertransference revulsion, I was under no illusion that it was in me too, and intended to be there. To continue the bowel metaphor, she claimed a therapeutic victory in having evacuated herself of wasteful affects through her own hard work on herself, and although she disowned responsibility for having anything to do with the useless, stirred up (but simultaneously stuck) toxic affects of others, she could not quite let go of her blissful link to their convulsions.

Experiencing my own inauthenticity

I had initially felt overwhelmed only from time to time by the as-yet-inarticulated false self in Deirdre that I felt I'd helped to create – a self I experienced as profoundly uncreative, humourless, contractual, forensic, enforcing, violent and anti-social – but towards the end of the therapy I came to feel the constant force of a peculiar fear of becoming non-existent as a therapist for Deirdre if I did not support her as-yet-inarticulated false self by withholding analytic exploration of it. I did not 'voice' this internally to myself, but the force of this fear existed as a dis-ease, an 'unthought known' (Bollas, 1987, p210) waiting for its own articulation within my countertransference. At the time

though, my therapeutic tools disabled, my internal state roamed uneasily around my incompetence, my pretensions, my inauthenticity – nothing had been said, but I knew she wanted me to feel that there was only one throne in the room, and I was clearly the pretender to it. I frequently felt paranoid, panicked, culpable, and ashamed. What was I *thinking*? That *I* could help her to achieve some reflective space?

Just because you're paranoid, doesn't mean they're not out to get you.

However careful I thought I had been in not directly interpreting Deirdre's defences as paranoid, Deirdre's ultimate triumph was to get me to acknowledge that her colleagues *were* probably out to get her. By this period in the therapy, Deirdre had succeeded in numerous subtly divisive manoeuvres. Important alliances with other organisations were disrupted through disowned refusals to co-operate with joint projects, financial backers were fed information that was calculated to divert and disarrange loyalties, and, inside the small business where she worked, the work agenda was constantly halted to determine that the minute-taking meant exactly what Deirdre intended it to mean. Often, she'd push for a certain interpretation of the minutes simply to achieve the satisfying effect of convincing them that she had a hidden agenda when she had none except to provoke suspicion of one.

After months of being trawled through grievance procedures, her harried superiors at work devised a plan. It was announced to all the staff that when the organisation changed its original structures, everyone would need to resign, and then re-sign a fresh work contract, which would be a temporary contract only. A newly introduced democratic peer review rating system (which Deirdre would clearly fail, as by her own admission no-one in her office voluntarily spoke to her any longer) would determine once in every six month period if individual contracts would be renewed.

Infused by Deirdre's paranoia, and amply supported by my own dread and loathing, I felt in no doubt that this was indeed designed to 'eliminate' her. I was being authentic and truthful when I agreed with her that her work relationships were fraught with tensions, yet I felt desperately false. She was gratified that I conceded the possibility that her colleagues may have taken this step to put brakes on her. However, she did not go into a paranoid panic; she calmly sought legal advice, established that this desperate ruse constituted an unfair labour practice, and then moved through the offices in the guise of a humble barefoot lawyer announcing this fact reassuringly to all her co-workers, whom she described with great satisfaction as looking noticeably crushed at her disappointingly 'good

news'.

I could see how her colleagues had been confused into underestimating her, I could sense the triumphant and malignant intrapsychic objects driving her hate, yet I could not really 'fault' her commitment to her newly acquired calmness with colleagues. She had obeyed the 'letter' of my therapeutic endeavour to help her to put boundaries in place to kerb her aggressive outbursts, but she had succeeded in violating the 'spirit' of the endeavour in ways that defeated both others and myself. At that point, I remained merely incapacitated; I was still unable to move into the intersubjective space that would allow me to own the extent and depth of my own dread and loathing of her *modus operandi*.

Don't look at me in that tone of voice.

There was a sense towards the end of the therapy that Deirdre's "innocent" gaze was slipping, or perhaps sheer inflation and omnipotence was threatening to overwhelm the uncharacteristically low-profile that "innocence" required of her. After the triumph of her legal sleuthing, she took to taunting her envied superiors at work with instances of "dumb insolence" that were calculated to be intensely provoking. Accused of muttering under her breath and making sarcastic and demeaning and rolling eye movements during someone else's talk at a meeting, she denied this and insisted that she merely battled to see - even with her glasses on - and everyone knew that when she was intellectually roused, her lips tended to make syncopated movements. Eventually, her disturbed colleagues called a meeting of the entire staff, where in the end she was simply accused of "attitude", and warned that she should reflect in particular on her" F**k you!" attitude.

She was triumphant in the therapy, rocking on her chair with glee,

> " Phfff! Attitude! Now who can argue with attitude! Can they measure it? Are there rules written about it? Who's to say that your word is better than mine is where attitude is concerned? I mean, how can you *prove* "attitude? Can you measure it?"

Bollas trenchantly refers to this intrusive messing about with others' internal contents as the molestation of the psychic - in the vernacular a literal "mind-fuck", a

> ... forcing of this primary state upon the other...If this is a phallus, it is a maternal phallus, delivering its power (as the affective) into the other, an intercourse that consigns the other to

dyadic oblivion, as out of this passion, nothing emerges. (Bollas 1999, p.129)

Giving up on Deirdre

On this occasion, back in the room, she relayed the frustration her colleagues felt when she disavowed her bad attitude with mirthless gales of laughter. It was the first time she had owned the inherent provocation to me. Thereafter, it was this shameless, conscious manipulation that began to feel increasingly psychopathic to me. When I queried her laughter and suggested that she must also be feeling very isolated in such an antagonistic workplace, and how hurtful it must be to have all one's colleagues conspiring to get rid of one, she initially denied it, but when I persisted, she dissolved into silent short-lived tears. I felt sadistic, but when she kicked out of her grief with fresh rage and paranoia, I felt complete despair. For the first time in a year and a half, I really wanted to give up on this therapy. I admitted as much in my next supervision period.

The paranoia of the intern

It is common knowledge that all interns undergo a certain degree of paranoia occasioned by the continual atmosphere of rigorous assessment and feedback that the course requires. In my own therapy I dealt often with how brittle I was, with how difficult I was finding this internship year. I swamped my therapist with tortured detail, and avoided working in the transference, just as Deirdre did with me. I felt attacked by Deirdre, and assailed by my projected fear of judgement around my incompetence. With hindsight it became clear that my own paranoia outside the room fed into and heightened the paranoia I came to feel in the therapy with Deirdre, and that her largely split-off paranoia was now lodged in me.

There were other forces outside the intern's training that heightened my feeling of being attacked and judged. Throughout Deirdre's therapy, I was negotiating the terms of a drawn-out divorce settlement, and was thus predisposed to my own persecutory fantasies and narcissistic wounds. The undiagnosed illness of my young son - dismissed by several paediatric experts as malingering on his part and neurosis on mine - had suddenly been diagnosed as a tumour requiring immediate surgery, and then also extensive post-operative care that I had to arrange by what felt like remote control once I had used up my intern's leave.

For part of the therapy, I was placed for intern training at C23 – a psychiatric emergency ward - and

as the first intern there for fifteen years, felt simultaneously over-observed and under-utilised as a psychologist in the overwhelmingly psychiatric environment. Unforeseen circumstances in the public health system meant that my case supervisors for Deirdre changed three times during the second year of the therapy; the adjustments I needed to make were always acknowledged, but when I was in a depleted mood, I felt uncontained and insufficiently supported. I wanted to remain open to feedback in supervision, but initially found myself responding internally as though I had been attacked, particularly in relation to the therapeutic impasse with Deirdre.

There were yet other more reality -based fears that had to do with the ethics involved in the intern training. The M1 and M2 training supervisors are there to support and train interns, but are also there to ensure those ethical standards are adhered to in the therapies. This ethical role that supervisors provide was called on several times in the therapy with Deirdre, as her parenting raised difficult and complex issues with regard to the identification of reportable child abuse. As both Deirdre and her son were being treated, there were several professionals attached to their cases, all with differing appreciations and clinical evaluations of Deirdre's difficulties that threatened to split the ranks of those involved. Inevitably, the added spectre of my own ethical decisions now also being 'implicated' in the assessment of my management of the case, added to my sense of having to exercise extreme vigilance and caution.

While I understood that external pressures were impacting negatively on my ability to process material arising in the course of the internship training, I lacked the time within the pressurised schedule of intern training to create mental and affective spaciousness around these impacted experiences. Fearing that I might be overwhelmed unless I paced my resources, I wedged myself into a survival straightjacket, taking what felt at times like a persecutory internship, 'one day at a time'. As a result I experienced myself as inflexible, ahistorical, uncreative, unevocative, and paralysingly 'concrete'. Internally I felt shamed by my inability to think through Deirdre's self-representations in psychodynamic ways, and I speculated that "others" might feel I was failing to justify my selection as a trainee therapist. While this was true in relation to the therapy with Deirdre, had I been more able, in the heat of the therapy, to work more consciously with Deirdre's particular intersubjective claim on my inner life, I would have found it curious that these feelings of vulnerability, shame, and of impending attack were very largely absent from the therapeutic space I enjoyed with other patients. Bollas comments on this process thus,

> Indeed, if what we refer to by the concept of countertransference is not to lose its integrity,

> then we must acknowledge more frankly that in the midst of countertransference experiencing the analyst may for a long time indeed exist in an unknowable region. To be sure, he may know that he is being cumulatively coerced by the patient's transference toward some interpersonal environment, but analyses rarely proceed with such clarity that the clinician knows in *statu nascendi* what and who he is meant to become. (Bollas 1987, p.200)

I would add that the experience of being a trainee psychology intern is itself a transitional and intersubjective space, its own *statu nascendi* in which we are striving to know what and whom we are to become as therapists, and that this lays down a substratum of stress which frequently, although not uniformly, reaches its most creative potential only after we have completed the training.

The necessity to become situationally ill

Bollas writes, "Each patient suggests an environment within which both are meant to live a psychoanalytic lifetime together, and the analyst must suffer the illness of such place" (1999, p.142). Although not as familiar with this concept as I am now, I was aware of it, more especially with regard to Deirdre's ability to 'hotwire' me to her experience of her inner world. But in the previous months of therapy, in the 'disturbed and disturbing environment' occasioned by my situational paranoia and Deirdre's violent innocent enactments, I had underestimated the extent to which the therapeutic relationship itself had become the occasion of a split. Both Deirdre and I had split off from our personal realities into 'false self' adaptations.

I needed time and 'space' to transform the valuable material arising in the countertransference into thought, as I was no longer clear about what was internally generated material, and what was externally stimulated in the intersubjective space.

The necessity of failure

Having finally acknowledged that I despaired of ever being able to be of any therapeutic assistance to Deirdre, I now stewed in a rampantly paranoid broth about her. My countertransference moved between projected hatred and humiliation, and her omnipotence and my own omnipotence;

> She hates me, she despises me, she's set this whole thing up so that she can throw all my efforts back in my face. She's been playing with my head all along. How could I have given her the benefit of the doubt? She played the naivete, so that I would explain 'the rules', and then

> she mimicked me, playing them like a monster. She's a Frankenstein - and I created her! At least before we could all see Deirdre coming from a mile away, but now she's submerged, she's a psychopath. She's not just damaged, she's got a piece of DNA missing, she's inhuman, she's... diabolical! She hijacks every session with her hateful stories of obliteration - its like being forced to watch snuff movies that one's been an unwitting accomplice to. At the very least I'm colluding with her - if not in the way I've gone about the therapy itself, then in what I *haven't actually* done in the therapy...

I was filled up with these anxious inner conversations that at this point almost entirely replaced consideration of Deirdre's enactments and what they could mean about her inner world. I was suspicious of her every motivation without being able to usefully associate these to anything beyond an acknowledgement of their link to the experience of being overpowered by early objects. I knew I felt hated, and hate-full, but I simply could not maintain an internal potential space to recognise how important this was.

I was exhausted. I told my supervisor I'd given up, that we only had two more sessions left anyway, and Deirdre was resolutely refusing to explore termination issues with me. My supervisor was unsurprised, clear; "She needs you to give up on her. She needs you to feel hopeless before she can feel hopeful."

Termination

Deirdre's parting words to me on termination were not, thankfully, "Have a nice day!" Nevertheless she was still resolutely resisting any suggestion of reviewing the therapy in the light of feelings it might be bringing up, or in terms of any good she might lay claim to having appropriated from it in the year and a half that I had been seeing her - no doubt in case I used the occasion to lord it over her. I expected this recalcitrance, but despite it nevertheless apprehended a sense of deep foreboding and overshadowing in relation to the impending termination. I expressed this to her in milder terms and wondered aloud to her if this could mean that she was feeling some sense of abandonment by me because of the impending termination? No, not at all! She laughed, after all I'd made it clear from the beginning that therapy would end on this date, and she'd diarised it. No, actually she was feeling "exceptionally sad" about an aunt's funeral that had taken place over the weekend.

She went on to express deep and uncharacteristically quiet sadness over the death and the paltry funeral of this penurious and distant aunt. She mused openly, "Who would mourn for *her* when she died?" "Without family or friends, who would say prayers for her?" And "Poor Seamus - the only thing I ever got right - whom," she queried (socially isolated as they were), "would accompany him to *her* funeral?" I was struck by the absence in Deirdre of her characteristic narcissistic and grandiose defences. She was showing me a genuine capacity for sadness that for the first time did not descend into autistic and somatic grief, and which she did not appear to be trying to kick away from with escalating anger. She was being reflective for the first time in the therapy.

Death had come to Deirdre like the proverbial thief in the night, and appeared to have engendered in her for the first time a realistic recognition and assessment of her severely disappointing relationships, the ephemeral capacity of her robust defences to protect her (and by extension, Seamus) and the emptiness of her future prospects. Of course I felt that she was unconsciously mourning the end of the therapy, and acknowledging the need to give up the pathological modes of behaviour and self-experience that provided only precarious pleasure and security - but nevertheless I did not interpret. Deirdre was musing with herself, and it felt too rare to interrupt.

Her mother, she suddenly announced briskly, would never have allowed so paltry a funeral to take place had she been in town. She would have arranged several clergy, and a good deal of pomp and prayers and ceremony. I was surprised by this sudden positive intrusion into the therapy of the mother who had been banished at the end of last year, and I was keen to explore the visitation, and explore whether she could take in some good. " Well, it sounds as though you and your mother share at least this in common – a deep respect for family, and for faith" I ventured.

Deirdre was withering; it was not hard to see how *completely* different she was from her mother! In fact if I really wanted to review the shifts that she, Deirdre, had made, she could spell it out for me; she would point out all the things she had done that put her in an entirely different league from her mother. Deirdre had moved out of her reflective space. Once again, I felt that I had been rejected as a container for her troubled affects.

Her capacity to 'change'

In this default manner, she proceeded to do some of the work of termination, to outline all the personal 'shifts' that she felt she had made - shifts she was careful to establish as not having

happened in the therapy, or with me - but that she had made in the course of her adult life These shifts she felt distinguished her as clearly superior to her loathed mother. She went through what was clearly a carefully thought out but staccato list; (1) She had educated herself, got a degree. (2) She'd left an abusive husband. (3) Bought herself her own car. (4) Taken herself to therapy when she needed it. (5) Taken her son to therapy when he was struggling with his father's abandonment. (6) Was not an abused housewife taking *kak*, but a working woman. (7) Held down a good job. (8) Travelled abroad frequently. Deirdre made it clear that these were not up for discussion, and that she was not prepared to "share" them.

It was an impressive list, given her self structural impediments, and I could appreciate that she felt that she had made good, as well as negotiated more cohesion for herself than her own borderline mother. Compliant at last with the 'letter' of the therapy, she believed she had finally risked allowing me to see where she thought she had the capacity to "change", even if these were inflated versions painstakingly distanced from any relationship with me, both chronologically and emotionally – but she was prepared to risk this only at the very end, when she felt she had brought me to despair, and driven it home that I had 'failed'. I realised that she needed me not only to fail her, just as she needed to show me that I had failed Seamus, but then also to despair of her, so that I would have a visceral as well as a thinking / feeling understanding of her deeply disturbing primary object. However, for a short space she had also allowed me to apprehend her 'unthought known', her mourning around finality and non-negotiable endings, and had wired me up to feel how bereft she felt about all her losses, including the impending loss of the therapeutic space with me.

With further understandings and reflection, I could track how in the therapy with Deirdre, the possibility of intersubjective discourse had been displaced by my private affects, how any chance at "perceptual reciprocity" had been intruded on by "projective displacements" (Bollas 1999, p.138). Eventually, I could even value the way in which Deirdre had invited me into her paranoid world, so that I could, in Bollas's formulation, begin to find her in myself. However, this became possible only at the point that I had despaired of her, was sickened by my own sense of futility - and had therefore really taken on board that there were indeed 'two patients' in this therapy (Bollas 1985, p.202).

Bringing out the Fatted Calf for the Prodigal Therapist

When Deirdre left my room for the last time, she was insouciant. I watched her walk down the long passage, feeling all the desolation of a pencilled-in date whose time has come, and now has gone.

At the end of the passage, she spun around as though she knew I was still there, and called out, "When Seamus is a teenager, and he's a fuck-up, I'm sending him to you!" and strode off round the corner. It was to be expected that she would conclude that in wanting to discuss termination issues with her, it was affirmation that I was fishing for, and I knew she would be contemptuous. I was surprised when she managed a 'compliment' - a back-handed one to be sure - but it was the only form of acknowledgement I had received from her in a year and a half. Consequently I made much of it in my own musings since our termination, struggling as I was to lick honey from the razor's edge.

CHAPTER SEVEN

CONCLUSION

In therapy, even more than in life it would appear, good intentions can paradoxically pave the path to hell. The most valuable learning for me in the therapy with this patient was that I would need more than attunement and the well intentioned therapeutic endeavour to feel and think my way through my own inner states on the path to Deirdre's internal world.

The necessity of showing me her despair of being understood.

The clinical value of this therapy lay in the unerring way in which it pointed to split-off aspects of both my patient's and my own inner reality. Faced with an excessively vigilant, outwardly compliant, overtly aggressive, subtly disconfirming and deeply unhappy patient, I had struggled to 'fault' her commitment to therapy - but felt her disowned hate, my own ineptitude, and finally my own split-off hate, keenly. Assessment of these disowned affects within the intersubjective field allowed me to understand that in the noxious experience of being thwarted lay the key to understanding the psychodynamics that drove the fuse of her 'blissful' turmoil, as well as her radical innocence (Bollas 1999, p. 127). The uncreative, unplayful and "cumulatively coercive" way in which the therapeutic space was commandeered was analogous to her experience of disturbed early relating, and I had needed to become lost inside this world. It made sense that Deirdre needed me to feel profoundly unmet and unreceived in deliberately provoking ways, to empty me of hope and to make me despair of the possibility of understanding her before she could begin to show me the possibility that she could make any shifts at all. In Winnicottian terms, I needed to surrender myself to be used as an object. To be thus overwhelmed by her unthought known was the precondition for facilitating the necessary destruction and survival of myself as the object.

The attempt to communicate shared reality

There is a valuable honesty of sorts involved in the 'phoney representations' of the false self that Bollas speaks of. Although he does not identify violent innocence as peculiar to borderline pathology, his language captures how we might begin to understand violent innocence and other forms of projective identification as a deeply flawed attempt at languaging a shared reality. I have suggested that violent innocents such as Deirdre may dimly grasp the 'deceptions' involved in

creative misrecognition, but may struggle with the 'logic' of them. Violent innocent enactments take place where pre-verbal intrapsychic processes cannot find a language for the disturbance at the core of the self, and Bollas's own language may be a useful way at looking at the distorted hospitality that this self attempts to present. He describes a process whereby the "recipient" (not the 'other') is "invited" into "a carefully managed and dehydrated internal world" in which the recipient is the object of "sponsored" confusion and is thereby "strangely caught up inside the other". I came to see this invitation to borderline reality as 'truthfully' the best that could be offered - it was uncomfortable, but to her, it was 'home', and I had been invited in.

The therapist's regression

I had been insufficiently prepared for the process of my own regression in the countertransference. Along with a paranoid fear of being attacked, feelings of being thwarted, and finally envy of Deirdre's easy disavowals, by the end of the therapy I was compelled to acknowledge the value of the intersubjective space as a means for finding my own disowned futility and fear within this space, and for making sense of Deirdre's violent innocence as a response to my therapeutic endeavours to put brakes on her "conjuring of the primary" (Bollas 1999, p.129). Through the process of having my own therapeutic tools ransacked, I came to understand that she viewed her confinement to the banal shores of the non-reactive 'Liberated Zone' as a theft initiated by me that left her vulnerable to be taken advantage of by others.

Normalising the 'not-knowing-yet-experiencing' countertransference state

The challenge that the therapies of more severely character disordered individuals present is considerable, and for inexperienced therapists such as myself, these challenges need to be normalised, "The most ordinary countertransference state is a not-knowing-yet-experiencing one" (Bollas 1957, p203). Bollas's views on the expressive uses of the counter-transference introduce a compassionate overview that is free from strictures to, or judgements of, either patient or therapist. The process of analysis is rather one where the analyst must work to put his/her "self states into language", and must use countertransference experiencing for "eventual knowing" only. This is an admission that the hostile environments frequently created by patients require a tolerance for our own regressions,

> The capacity to bear and value this necessary uncertainty defines one of our most important clinical responsibilities to the patient; and it enhances our ability to become lost inside the patient's evolving environment, enabling the patient to manipulate us through transference usage into object identity (Bollas 1957, p.203).

Using the transference-countertransference material

The question arises of whether the theoretical focus of this dissertation has enabled a different way of conceptualising this particular therapeutic impasse with a borderline patient of paranoid presentation, and whether the impasse could be traversed by using the transference-countertransference material? With regard to this therapy, I do not doubt that it would have been very challenging to offer up for Deirdre's consideration those aspects of her internal world that she found unbearably painful – and to have done so while holding onto that part of me that felt futile and despairing. While more experienced therapists with more of a situational capacity for "generative countertransference regression" (Ibid. p.204) have tried and sometimes failed with similarly disturbed patients, the point that Bollas makes is that the analyst is really required only to "maximise his countertransference readiness" (Ibid. p.203). With hindsight, that readiness, which is about creating a transitional space in the therapy, rather than attempting to put boundaries in place and facilitate adaptive strategies - would have been the most useful therapeutic endeavour to have employed with Deirdre.

Non-threatening use of the indirect aspect of the countertransference

With regard to a hypothetical ongoing therapy with Deirdre I can only speculate on the basis of what has already transpired between us how she would have reacted to a therapy that made direct and non-direct use of the countertransference material. I believe however that if I had put indirect aspects of my countertransference to her as being curious, or of interest in some way that she could safely ponder as part of her symbiosis with me as the idealised omnipotent self - such as, for example my loneliness in the therapy occasioned by *her* loneliness - she might well have been able to tolerate this. Bollas suggests here those kinds of indirect interventions such as when the analyst says, ""I feel", or "I have an idea that", or "I sense that". Such interventions, however, are countertransference inspired, and indicate some aspect of the analyst's trust in his subjective states of mind." (1987, p.231) Such indirect interventions conceivably may have re-established my own

sense of personal reality in the therapy - as opposed to the inauthenticity brought about by my own false self adaptations in response to her false self work.

The therapist's use of 'self contemplation'

Additionally, as Bollas outlines, one can use this sort of self 'contemplation' to explore parts of one's own subjectivity that are non-threatening to the patient, and use this as a modelling process to transparently and reasonably explore one's own cul-de-sacs and states of mind. To have owned my own split-off aspects of 'our' mutual intersubjective reality might have laid the basis for a mutual exploration of Deirdre's own loss of personal reality. This indirect use of the countertransference is one way in which I might have been able to present otherwise intolerable interpretations - as free associations reflecting my own self states - that would not have made her feel suddenly threatened or abandoned in the ways that a patient still operating from a position of magical omnipotence with the therapist feels. Additionally, to have used myself in the therapy in this way might well also have decreased the alarm and distrust of the seemingly unsupported interpretations that I have cited elsewhere as being so inimical to Deirdre, and to borderline patients generally (Giovaccini, 1989).

Direct use of the countertransference

One can only speculate whether building a tolerance in Deidre for this kind of indirect use of the countertransference for the purposes of linking her with parts of her disavowed internal world would have built up enough resilience in her for moving onto the direct use of the countertransference. Bollas argues that having established oneself as a useful and unthreatening source of material in the therapy by putting words to one's own subjective states of mind, in time the basis will become established for moving on to analyse the patient's own self states. Bollas conceives of the direct use of the countertransference as one in which the therapist can admit to how it feels to be one of the objects in the patient's environment (1987, p.210).

The therapist as the transformational object

If we agree with Bollas that turbulence is the borderline's actual object of desire, and

> ... not simply a decompensation occasioned by internal objects falling from a structural place, or triggered by blows in reality, but as a conjuring of the primary – the self feeding on its own hate and anxiety – we may see why this person pursues the very disturbance with abandon.

(Bollas, 1999, p.134)

We may then be able to make use of the transference-countertransference to help the patient to understand that they take perverse pleasure in contacting and sustaining suffusion with this object. I am thinking here particularly of Deidre's oft-stated query, "Why? Why me? Why do I always attract this shit?" Bollas suggests that through engaging oneself as a transformational object, it may be possible to eventually enable the borderline patient to understand that they obtain unconscious gratification from creating intensity and turbulence, and that the latter gratifications are actually sustained through their characters.

The healthy resolution of disillusionment

Macaskill (1982) suggests that the usefulness of Winnicott's theory of transitional phenomena lies in the way it allows us to pay attention to the personal and existential meaning of the borderline's patient's material as expressions of transitional phenomena. The therapist acts to,

> ... ameliorate a process of disillusionment that is occurring spontaneously, but which without his presence and empathic comments leads to fragmentation and reactivation of primitive defences. The therapist does not produce disillusionment, but instead makes healthy resolution of it possible. (1982, p.356).

The point of facilitating the gradual understanding that intensity and turbulence constitute the deepest truth at the core of the borderline self, and then convincing the patient that these gratifications may be safely explored and depotentised is to " to allow redistribution of pleasure along different lines" (Bollas 1999, p.134). If Deirdre's pleasure in thwarting others could be explored through a joint examination of my sense of futility and uselessness in the face of it, and this itself could be explored in the light of her experience of needing to comply with a withholding and unempowering maternal object, then we might begin to be able to explore together why it is that she always attracts "this shit".

Through identifying the personal meaning of her ontological insecurity through her use of transitional phenomena or substitute formations, we might eventually have been able to look at why *mis*recognition is actually all about sustaining illusion in the interests of connectedness, and about how *mis*perceiving in the interests of deep play was a process probably denied to her. Allowing myself to be used repeatedly as a non-interpretative and non-challenging transformational object by

"giving the patient back what the patient brings" (Winnicott 1962 in Macaskill, p. 355), might have given Deirdre the experience of having her emerging sense of authenticity affirmed - to the point where she might eventually have been able to explore and arrive at new meanings and understandings by herself.

Equivalent and concurrent self-relating

Understanding the way in which the transference-countertransference anxiety can be accessed in ways that promote an equivalent and concurrent self-relating (perceived as neither retaliatory or withdrawing), offers an authentic means for the counterbalancing of paranoid and borderline patient's intrapsychic processes with inter-subjective ones.

Relational theories of intersubjectivity offer a rigorous and compassionate way to use one's subjectivity that can be usefully applied in therapies with disturbed patients, while bearing in mind Bollas's caveat "that there are some patients to whom one could not ever usefully express one's experience as their object" (Bollas 1987, p.211). The greatest hurdle with regard to Deirdre would initially lie in using the transference-countertransference material in indirect ways in order to avoid those negative therapeutic impasses brought about by interpretations she receives as either intrusions or thefts. With her fine attunement for phoniness, I believe she could be disarmed by, grateful for, and finally even responsive to authentic messages from a 'democratically' owned intersubjective state of 'unknowing' – one that was perceived by her to be a jointly-owned striving to become a thought known. My sense of her is that a concurrent and equivalent self relating could be successful precisely because it would 'radically' address her dread of and attraction for disavowal and repudiation.

Holding up the mirror to Medusa

A concluding image suddenly arises here of Perseus and the Gorgon, perhaps because the myth encapsulates some of the same features of the paradigm shift involved in intersubjectivity and Bollas's exposition of expressive uses of the countertransference. Eschewing a foolhardy (and inevitably fatal) full-frontal assault on this dauntingly defended creature, Perseus's 'paradigm shift' is to use a mirror to 'indirectly' approach Medusa in order to avoid being turned to stone by her gaze. Having disabled her defensive hair of live attacking snakes through using the mirror, he was eventually able to turn around and 'directly' hold up the mirror to Medusa. His

genius lay in being able to both *show her to herself* and avoid being turned to stone in the process. However, Perseus did more than show Medusa to herself; he also gave her a direct experience of what it was to be her object. Holding up the mirror in this way puts one in mind of Bollas's suggestion that there are 'rare but significant occasions' (Bollas 1987, p.201) when the analyst may analyse his experience as the object of the patient's transference in the presence of the object.

---------- Finis ----------

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ACCREDITATION

The term 'Invincible Defeat' used in the title of this thesis comes from the song 'A thousand kisses deep" by Leonard Cohen's on his album "*Ten New Songs*" (2001 Sony Music).

The phrase "going to pieces without falling apart " used on page 15 of this thesis is taken from the title of an article by Dr Mark Epstein. The phrase "licking honey from the razor's edge" used on page 69 is taken from the title of an article by Maura Sills. Both these articles are in Watson, G, Batchelor, S. & Claxton, G (Eds.), 2000. *The Psychology of Awakening – Buddhism, Science and our Day-to-Day Lives*, Samuel Wieser Inc; York Beach.